18 MARCH 2000

CHEMIST & DRUGGIST

THE NEWSWEEKLY FOR PHARMACY

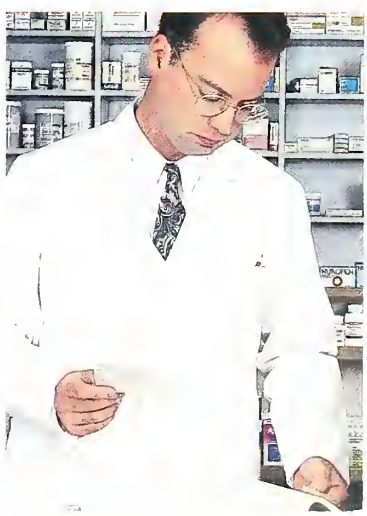
DoH says 'yes' to pharmacist prescribing

Scots 'half way' to full electronic script transmission

OTC prescribing on trial in Scotland

Shortline wholesalers face tighter controls over cold storage

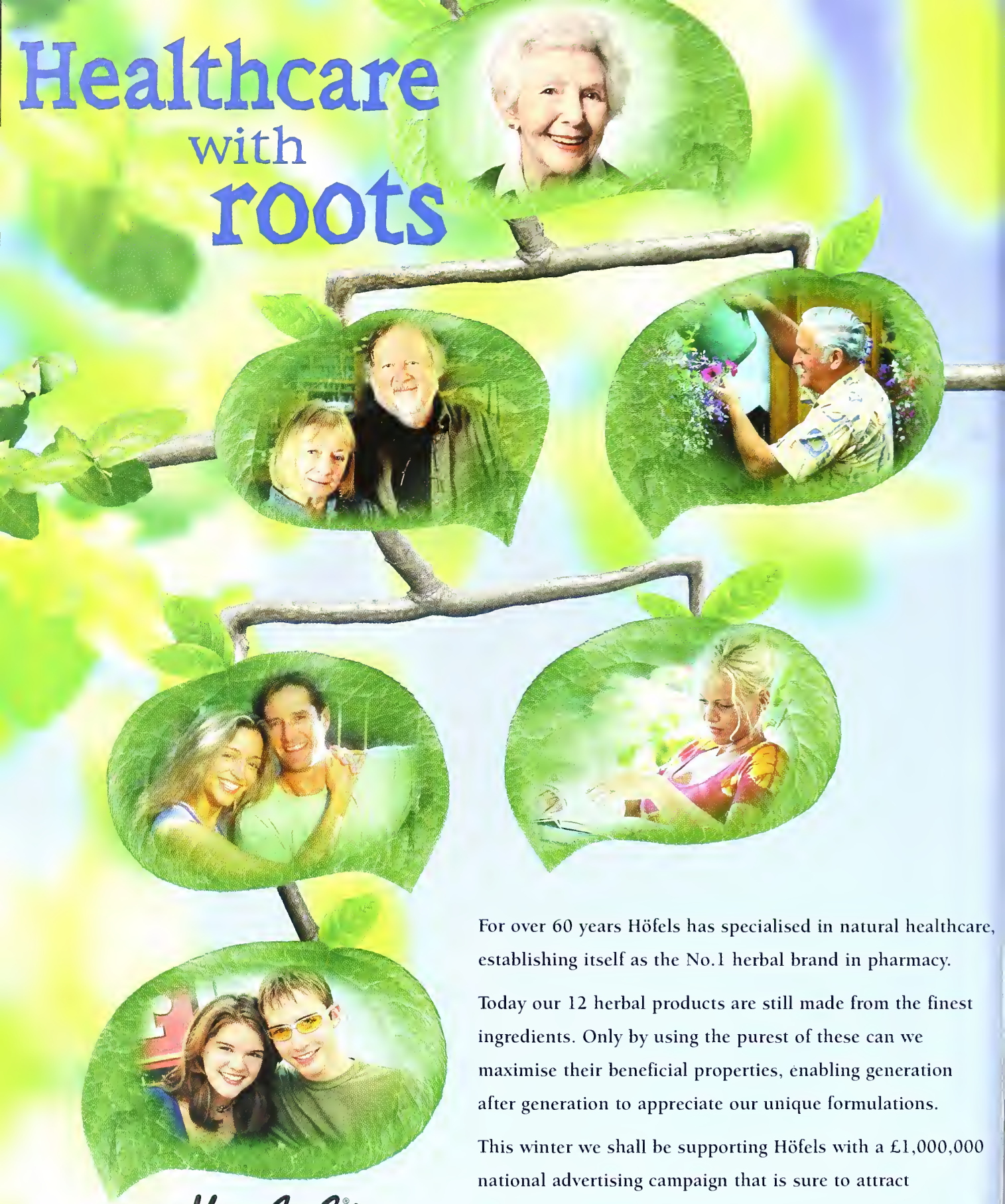
Manufacturers fail to stop PI repackaging



***Update:** keeping up with all the evidence*

Online at http://www.dotpharmacy.com/

Healthcare with roots



For over 60 years Höfels has specialised in natural healthcare, establishing itself as the No.1 herbal brand in pharmacy.

Today our 12 herbal products are still made from the finest ingredients. Only by using the purest of these can we maximise their beneficial properties, enabling generation after generation to appreciate our unique formulations.

This winter we shall be supporting Höfels with a £1,000,000 national advertising campaign that is sure to attract many new customers.

So stock up on Höfels. We're at the root of your herbal business success.

Höfels®

nature's own pharmacy

Höfels Pure Foods Ltd, Hedon Road, Marfleet, Hull HU9 5NJ

CHEMIST & DRUGGIST

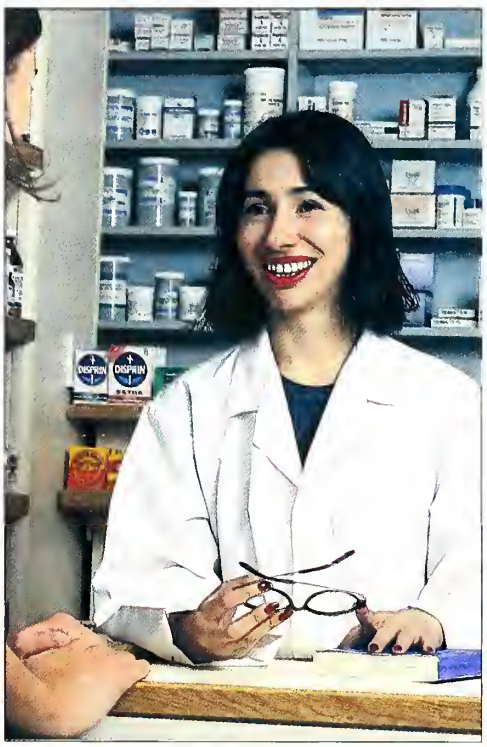
THE NEWSWEEKLY FOR PHARMACY

VOLUME 253 No 6231 140th YEAR OF PUBLICATION ISSN 0009-3033

REGULARS

COMMENT

March 2000 will go down as the month that the Department of Health, at last, pledged itself to pharmacist prescribing (p4). Admittedly this undertaking applies only to England for now, and the timescale is vague - "the DoH will consider legislation as soon as parliamentary time allows". The cynics will say that yet again pharmacists are playing second fiddle to nurses. They might also suggest that the proposals to clarify the legality and scope of group protocols (or patient group directions - PGDs), also issued this week (p6), have forced the Department's hand. In practical terms, there may not be too much difference between supplementary prescribing by pharmacists and the supply or administration of medicines under PGDs. But this is to overlook the tremendous opportunity that this week's announcements offer. The period before legislation gives a valuable breathing space for the Royal Pharmaceutical Society to set out publicly exactly what it wants to achieve for pharmacists from this breakthrough. The DoH will certainly have some pretty firm ideas. It may wish to follow the nurse route with a limited prescribing list tailored to certain defined therapeutic categories. Almost certainly the DoH will link prescribing rights to training and audit. There are also barriers to overcome. Supplementary prescribing means pharmacists and GPs are going to be thrown much closer together in treating and assessing certain groups of patients than they have ever been in the past. Doctors will need to be persuaded that pharmacists have the necessary competencies and have a clear understanding of their role. All in all, the only pharmacist who might be upset by this week's pronouncement is Professor Claire Mackie, the pharmacist who sat on the Crown Review Body and who has been quietly championing its recommendations at innumerable conferences and seminars ever since. She will have to rewrite her speech.



Editor Patrick Grice, *MRPharmS*
Assistant Editor Maria Murray, *MRPharmS*
Technical Editor Fawz Farhan, *MRPharmS*
Business Editor Guy L'Amable, BA
News Editor Charles Gladwin *MRPharmS*
Contributing Editor Adrienne de Mont *MRPharmS*
Beauty Editor Sarah Thackray
Reporter Steven Bremer *MRPharmS*
Art Editor Tony Lamb
Production Editor Vanessa Townsend, BA
Editorial secretary Jan Powis
Editorial (tel): 01732 377487; (fax): 01732 367065
E-mail: chemdrug@unmf.com
Price List Colin Simpson (*Controller*) Darren Larkin, Maria Locke
Price List (tel): 01732 377407; (fax): 01732 377559
Group Advertisement Manager Julian de Bruxelles
Group Advertisement Executives Simon Goddard, Christian Harris
Classified Executive Debra Thackeray
Advertisement department secretary Elaine Steele
Advertising (tel): 01732 377621; (fax): 01732 377179
Production Karen Way
Associate Publisher John Skelton *FRPharmS*
Group Sales Director Ian Gerrard

Chemist & Druggist incorporating Retail Chemist, Pharmacy Update and Beauty Counter

Published Saturdays by Miller Freeman UK Ltd, Sovereign Way, Tonbridge, Kent TN9 1RW
C&D on the internet at chemdrug@dotpharmacy.com
Website: http://www.dotpharmacy.com/

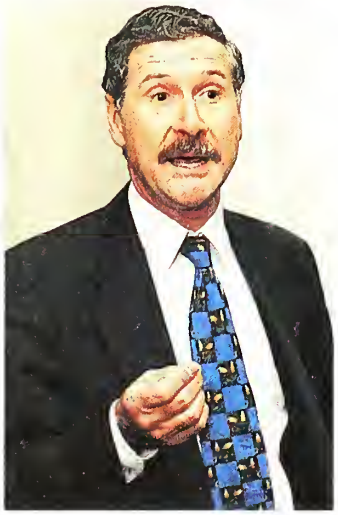
Subscriptions (**Home**) £137 per annum, (**Overseas & Eire**) $324 per annum including postage
£2.60 per copy (postage extra)
Additional Price List £78 per annum

Circulation and subscription Marlowe House, 109 Station Road Sidcup, Kent DA15 7ET Tel: 020 8309 7000

Miller Freeman

PPA ABC

DoH to give pharmacists the right to prescribe



Dr George Rae: the BMA has mixed views

Dr June Crown

'The Review of Prescribing, Supply and Administrotion of Medicines', led by Dr June Crawn, recammended in Morch 1999 on extensian af prescribing outhority to further graups af profassianals with particulor training and expertise in speciolised oreos.

The Review recammended that applicotions for prescribing powers should be submitted to an odvisary cammittee – the New Prescribers Advisary Cammittee – set up os a stotutory committee under the Medicines Act. This committee would ossess opplicatians fram both "independent" ond "dependent" prescribers.

An independent prescriber wauld be responsible far the ossessment of potients with undiognosed canditians ond for decisions obout the clinicol management required. A supplementary (dependent) prescriber would be responsible for the cantinuing care of patients wha have been ossessed by an independent prescriber.

Consultatian on potient group directions is being undertaken by the Medicines Control Agency. Copies of the consultatian document are at *www.open.gov.uk/mcohome.htm.*

The Department of Health is planning legislation to allow pharmacists in England to prescribe, as part of its response to the Crown Review.

Dependent prescribing by health professionals, including pharmacists, physiotherapists and chiropodists, will be considered "as soon as parliamentary time allows", said the DoH.

Legislation will also be considered, "to step up this supplementary prescribing to full independent prescribing ... subject to the development of first stage supplementary prescribing". This decision currently only applies to England. Scotland, Wales, and perhaps Northern Ireland will be free to make their own decisions.

John D'Arcy, director of the National Pharmaceutical Association, called the announcement "a very significant plank in the move to formal recognition of the pharmacist as a player in the primary healthcare team", and a "great start" in moving to an NHS prescribing role for pharmacists.

While Mr D'Arcy welcomed the move to "step up" to full independent prescribing, he said it was difficult to say how far that should go at this stage. And that the process must be carried out in stages. He suggested specialised pharmacists could have increased prescribing powers within their area if they could demonstrate the necessary skills.

But before legislating on pharmacist prescribing, the Government is to extend the scope of nurse prescribing, particularly in the areas of asthma, diabetes and minor injuries. All the changes are "part of wider moves to break down old demarcations between health professionals", says the DoH.

Alongside these developments, the DoH has begun a six week consultation (see p6) to clarify the law on the use of group protocols. Pharmacists are currently taking part in two schemes in which emergency contraception is supplied under a group protocol. One is in the Manchester area and the other is underway in Lambeth, Southwark and Lewisham. The Department says the new regulations are expected to be in place by July.

Christine Glover: a vote of confidence in the profession

The decision to clarify group protocol regulations means the Government recognises that this is something pharmacists should be involved with, said Mr D'Arcy.

If there is to be equity of access in the NHS, the issue of patients paying for medicines prescribed by pharmacists must be addressed, said Mr D'Arcy. The results of a pilot study on pharmacist prescribing on an NHS basis in Bootle are about to be published.

The British Medical Association has mixed views about pharmacist prescribing. Dr George Rae, chairman of the BMA's prescribing committee, said that he is more concerned about pharmacists prescribing dependently, when they are not liable for their own actions, than independently.

He is concerned that pharmacists do not have the skills to be able to prescribe dependently in areas such as hypertension, angina and rheumatoid arthritis. But he described independent prescribing for many minor self-limiting ailments as "fair cop".

Dr Rae acknowledges that having one local dependent prescriber for a GP would be workable, but is concerned about many different dependent prescribers acting for each GP. Because patients choose where they have their prescription dispensed, the potentially large number of satellite dependent prescribers may cause protocol problems, he believes.

However, if pharmacists could demonstrate an improved skill base and the correct educational set-up within the profession, they could be equally as well placed as nurses to prescribe, said Dr Rae. Nurses have made significant improvements to their professional education in recent years, and this has enhanced their position with regard to prescribing, he said.

Although no timescale is in place for prescribing legislation, Mr D'Arcy believes that even if there were a transfer of power at the next General Election, a Conservative government would back the legislation. It was a Conservative government who set up the Crown Review and Mr D'Arcy described pharmacist prescribing as a "cross-party issue".

John D'Arcy: the issue of patients paying for medicines must be addressed

Christine Glover, president of the Royal Pharmaceutical Society, said: "This is a vote of confidence in the potential of pharmacists to develop the use of their skills and knowledge to the benefit of patients."

The Society endorsed the Government's aim of providing easier access to healthcare. Pharmacists can make a further contribution to support nurses in walk-in centres and A&E departments, it said. The Society is seeking to explore with the Government ways in which patient safety could be assured.

£400k damages bankrupts rape case pharmacist

A pharmacist ordered to pay £400,000 damages to a colleague after falsely accusing him of rape has been declared bankrupt.

Lynne Walker of Gateshead, who is now using her maiden name of McDonald, was declared bankrupt on February 23 at Newcastle County Court. She is also facing a bill for £150,000 court costs.

The case has been referred by the Official Receiver to an outside insolvency practitioner at Jennings and Johnson Solicitors in Newcastle. Ian Kings said that he would realise whatever assets he could and distribute them to Ms Walker's creditors.

A Boots spokesperson confirmed that Ms Walker is still employed by the company.

Scotland halfway to electronic prescribing, claims SPGC

Scotland is halfway to full electronic transmission of prescribing data, according to George Romanes, chairman of the Scottish Pharmaceutical General Council.

Electronic prescribing will be a reality within five years, said Mr Romanes. The initiative, which has been allocated £4 million of funding, has reached a "halfway house" with the introduction, in April or May, of optical character reading at the Pharmacy Practice Division. This will mean that virtually all prescriptions can be priced without the need for operator input.

"We can't move forward on repeat dispensing systems through pharmacies with a paper-based system," said Mr Romanes. Doctors are also keen for pharmacists to move forward with repeat dispensing systems. "It's the one piece of their workload that they feel we could help them with."

Optical character recognition should not make much difference to contractors, said Mr Romanes, as they are already using the modified prescription forms. There are still problems to be ironed out, however. These include forms containing more than three items, and endorsing programs that do not line up endorsements with prescribed items.

Because "we are stepping into the unknown" with electronic prescribing, a multidisciplinary group has spent several months looking at two or three models for its introduction, he said.

George Romanes: it will be a reality within five years

Pharmacy OTC prescribing test in Scotland

A "community pharmacy prescription form" that will allow pharmacists to prescribe OTC medicines to exempt patients via the NHS is about to be tested in Scotland.

A formulary of drugs for minor ailments is currently being drawn up. Ten therapeutic areas are being considered, including head lice treatments, cough and cold remedies, and anti-fungal creams.

The pilot scheme will be operating in about eight to ten pharmacies in two areas of Scotland by the summer. An additional benefit of the scheme, according to George Romanes, chairman of the Scottish Pharmaceutical General Council, is that patients may need to register with their pharmacy for it to be effective.

The scheme will be similar to one in Bootle that will be publishing its results shortly, but "we are tartanising it a bit", said Mr Romanes.

The minister for health at the Scottish Executive, Susan Deacon, mentioned the scheme in a written answer last week. She was asked about the Executive's plans to make greater use of the skills and knowledge of community pharmacists, and whether these plans include greater integration of community pharmacists into healthcare provision.

"Pharmacists are increasingly being integrated into the extended primary care team and are playing a key role in the modernisation of primary healthcare services," said Ms Deacon. She mentioned three initiatives underway. One is the OTC prescribing scheme, another is the new national framework for pharmaceutical care in the community (*C&D* November 13, p4), and the final project involves exploring the potential for electronic transmission of prescription data (see above).

"We will continue to work with the pharmaceutical profession, health boards, and trusts to ensure pharmacists are fully engaged in contributing to the agenda for improving the health of the people of Scotland," said Ms Deacon.

Mentoring scheme needs volunteers

A pilot mentoring scheme for pharmacists has come to a halt because not enough volunteers have come forward to be mentored.

There are plenty of mentors for the scheme, being set up by the National Association of Women Pharmacists, but only a couple of pharmacists have wanted advice.

The mentors come from different ethnic groups and cover most branches of the profession – community proprietors and locums, multiples, hospital and industry. They are prepared to give confidential advice on career development to both male and female pharmacists.

Anyone interested should contact Mrs Arlette Alexander on 01392 275409.

Joint initiative offers research grants

The Medical Research Council and the Department of Health are inviting applications for research grants.

The joint initiative will consider proposals that address any areas of research of direct relevance to primary healthcare, providing they fall within the remit of the MRC's Health Services and Public Health Research Board (*www.mrc.ac.uk/Newpubs.html*). Pharmacy is specifically mentioned as an eligible area.

Applicants are encouraged to put forward a strategic plan for their research objectives, rather than take a one-off single project approach. Applications must be received by April 17 and the deadline for the receipt of full proposals, if invited, is likely to be no later than September 25. Funding decisions will be announced in April 2001.

Strategic grants for individual projects, and programme, trial, co-operative group and development grants are available. For further information phone 020 7670 5116 or e-mail *Primarycare@headoffice.mrc.ac.uk*.

400 in EHC pilot

More than 400 women have been supplied emergency hormonal contraception by 16 pharmacists taking part in the pilot study in the Manchester, Salford and Trafford area.

The average age of the women has been 24, and only five have been under 16. The scheme, which began on Christmas Eve, was originally expected to finish at the end of this month, but has been extended until the end of June.

IN BRIEF

Northern Ireland statistics

There were 1,952,309 items dispensed from 1,132,457 prescription forms in Northern Ireland in November, 1999. The ingredient cost was £20.64 million (£19.30m net). Discount was £1.334m, with oncost and other payments totolling £3.292m. The gross cost was £22.60m (£21.90m net). Gross cost per prescription was £11.5736 with ingredient cost £10.571. The net ingredient cost per prescription was £9.8877.

March Category D changes

PSNC has advised that the following Category D items are not listed in the March *Drug Tariff*: Hydrocortisone eye ointment 1 per cent, 3g, ichthammol ointment 500g, and indomethacin caps 50mg, 100s.

Epilim case clarification

A report about a prescribing error involving Epilim (*C&D* March 4, p5) suggested that a patient had suffered an overdose by having been prescribed Epilim 500mg four times a day. The report should have said that the patient sustained injury after being prescribed 2 x 500mg four times o day.

PSG conference

The Pharmacy Support Group is holding a conference open to all pharmacists on March 26 at the Royal Pharmaceutical Society. The morning session will look at women in pharmacy and the otternoon session will address community phormocy issues. Details are available from Hemant Patel on 020 8595 8978.

End the silence of the lads

A report has highlighted health problems including depression, stress and isolation among Scottish males. The Men in Mind report, 'Silence of the Lads', looks ot the mental health needs of black and minority ethnic men, particularly those in Edinburgh. Men in Mind can be contacted on 0131 553 3344.

Osteoporosis advert

The Notional Osteoporosis Society has launched a four-week television odvertising campaign to alert postmenopausal women to the symptoms of osteoporosis. The advert is being broadcast in the Anglia region.

Homeless drug use in Glasgow

Up to a quarter of homeless people in Glasgow have some form of drug dependence, according to a survey by the Office for notional Stotistics. Almost one in five were dependent on heroin. Over half reported hazardous drinking behaviour and 44 per cent had other psychological disorders.

PSNI won't clash with new-look RUC

Concern that the Pharmaceutical Society of Northern Ireland will be confused with the proposed Police Service of Northern Ireland has been allayed.

The pharmaceutical body had expressed concern at its February meeting that the initials of the new police force would be the same as its own. However, the Patten Action Team has responded to the PSNI saying it believes that the new abbreviation for the renamed Royal Ulster Constabulary will be 'the Police Service'.

Technician training Money normally reserved for pre-registration training could be switched to dispensing technician training. During the fallow year of 2000-01, the requirements on pre-registration training grants will be substantially reduced. The purpose of using the monies in the technicians' training programme would ensure that these monies are not lost to pharmacy.

NICPPET appointments Concern over the appointment procedures to the NICPPET committee was raised. The secretary said that three nominations would be necessary for the Department of Health and Social Services to select one nominee. Council was concerned that this procedure allows the DHSS to choose appointees, rather than Council.

Finance and house committee A report on PSNI's projected cash flow over the next two years was presented. The cash flow takes into account the appointment of the chief executive, a new photocopier and other purchases. A contingency of £5,000 is to be made in the Society's accounts to provide for the costs of statutory inquiries. A statutory inquiry will be held on May 10.

General purposes committee Progress being made in the bid to streamline committee work could include the possibility of holding successive meetings on one evening, and making provision for early referral of work to committees.

Nominations Mrs M P McElvenny and Mrs L H Stewart have been nominated to the Pharmacy Practices Committee of the Western Health & Social Services Board.

- The Queen's University, Belfast has nominated Professor B J Walker to Council.
- Miss A M Bowen, T G Hannawin, J Gault and Dr D J Morrison have been nominated to the Statutory Committee.

Reciprocal registrations The following reciprocal registrations have been accepted: P R Beck, Surrey; F S Maguire, Carryduff, Belfast; S T M Maguire, Newry.

May Ball The PSNI's May Ball will take place on May 13 in Templepatrick.

DoH plans to tidy up group protocols legislation

Department of Health proposals to change the law on how group protocols operate could affect the way medicines are supplied throughout the UK.

The Medicines Control Agency has issued a consultation letter (MLX260) outlining proposals to improve standards and to legitimise existing practices under group protocols.

The proposed legislative changes would permit the supply or administration of medicines under 'patient group directions' throughout the UK. However, their introduction into national health organisations would be a matter for each separate administration.

The DoH also intends that the changes should "strike a satisfactory balance between the promotion of new ways of delivering a range of healthcare services and the protection of public health".

The proposed changes follow recommendations from the Crown Review that the legislation should be clarified. There have been concerns that group protocols may not comply with the law if patients are not specified by name under the protocol.

The DoH is proposing to modify:

- section 55(1)(b) of the Medicines Act
- the POM (Human Use) Order 1997
- the Medicine (Pharmacy and General Sale - exemption) Order 1980
- Medicines (Sale and Supply) (Misc Provisions) Regulations 1980.

The DoH proposes an amendment that would allow pharmacists to supply POMs under an arrangement with a health authority in accordance with a 'patient group direction' (group protocol) without a prescription.

A patient group direction is a specific written instruction for the supply and administration, or administration of a named medicine in an identified clinical situation.

It applies to groups of patients who may not be individually identified before presenting for treatment. Patient group directions are drawn up locally by doctors, pharmacists and other health professionals, signed by a doctor or dentist, and approved by an appropriate healthcare body.

Currently, patient group directions can only operate in the course of the business of a hospital or health centre. It is proposed to extend this list of businesses to:

- health authorities
- NHS or primary care trust
- a doctor's or dentist's practice
- a body providing treatment under an arrangement made with health authorities, or trusts, for example, walk-in centres and family planning clinics.

The list of professionals who would be able to sell, supply or administer medicines under patient group directions includes:

- pharmacists
- nurses, midwives or health visitors
- optometrists
- chiropodists
- radiographers
- orthoptists
- physiotherapists
- medical laboratory technicians
- ambulance paramedics.

To exclude drugs used outside their licensed indications was considered "unnecessarily restrictive" because there are specialist areas where these drugs are used routinely.

The supply or administration of Controlled Drugs should be excluded from the scope of patient group directions, says the DoH, along with the supply of unlicensed medicines.

Comments on the consultation document must be returned to the MCA by April 18.

Warnings to appear on St John's Wort products

Health food manufacturers have agreed to overprint labels on St John's Wort preparations warning users to consult a doctor or pharmacist if they are taking other medicines.

The Medicines Control Agency has asked for comments by March 20 on permanent labelling. The text proposed at a meeting with industry representatives last week reads: 'Before taking this herbal product: please check with your doctor or pharmacist if you are taking any other medicines as St John's Wort may affect the way they work. Always tell your doctor or pharmacist you are taking St John's Wort if you buy or are prescribed a medicine."

The Health Food Manufacturers' Association asked its members last week to make sure that most products were overlabelled within the next two weeks and to make information leaflets available at point of sale. The leaflets, headed 'Advice from the Medicines Control Agency', contain the advice issued to doctors and pharmacists, but written in lay language. People with epilepsy, asthma, heart conditions or those taking warfarin or tablets following transplant surgery are advised to stop taking St John's Wort but to see a doctor or pharmacist before doing so, as the dose of medicine might need changing.

Those taking oral contraceptives or treatments for migraine or depression are advised to stop taking St John's Wort and mention it to a doctor or pharmacist at the next consultation, rather than urgently. People on HIV treatment are advised to stop taking the herbal product and to see a doctor who might suggest a viral load check.

The MCA is sending the consumer leaflet to pharmacists who may copy it and distribute it as they see fit, a spokeswoman said. Manufacturers would be expected to incorporate the revised information into package inserts. The National Pharmaceutical Association is planning to issue one copy of the leaflet with the April Supplement.

Manufacturers can incorporate the information into promotional material but the MCA's wording must not change, it must be given suitable prominence and there should be no suggestion that the MCA has approved any other wording. The information sheet might remain current for about six months but could change if there was evidence of further interactions.

Herbal practitioners are being asked to advise the public individually and give the sheet to patients where appropriate.

The MCA is to meet industry representatives on March 21 to discuss the permanent labelling.

INDUSTRY VIEWPOINT

Be on the right side of the internet divide

Pharmacy cannot afford to be on the negative side of the 'internet divide'. There has been a lot of talk about this so-called 'divide', and those that have access to the internet and those that do not. At present some 25 per cent of all homes have access, and by 2002 the Government wants access for all.

With thousands of new users going on-line each month this target may well be achieved, but in the meantime the 'internet divide' is there. The web gives consumers detailed information on every known disease and every available treatment. They can access a wealth of knowledge and use it to ask searching questions of the healthcare profession.

"The first pharmacies that effectively make use of the internet will achieve competitive advantage"

Indeed, there is a school of thought that says decisions on medication regimes should be a negotiation between equals, with patients having the last word. If pharmacists are to be in a position to fully respond to consumers' questions and play their part in the medicine decision process, then pharmacies must have internet access.

So who is going to pay for this? Well, if I may be so bold, it is a cost of doing business in a modern world. Pharmacy cannot afford to be on the negative side of the 'internet divide'. With telephone charges tumbling, the cost of connection is set to fall even further, with many predicting access will be free.

The tide of technology cannot be turned back. I am certain that the first pharmacies that effectively make use of the internet will achieve considerable competitive advantage through enhanced customer service and increased business efficiencies. The open letter to John D'Arcy from Vijay Mehta, published in *C&D* last week, provides an excellent overview of the possibilities.

One final thought. Through on-line pharmacies it is possible to gain direct access to P medicines. You can complete the on-screen form and request purchase. Consumers going into a pharmacy are denied this direct access. In a world of empowered consumers how long will this be the case?

Contributed by a senior industry manager

Xrayser

Topical Reflections

Some order emerging from the internet jungle

That the internet has the power to change all our lives is undisputed, but for many, and this includes community pharmacists, whether it will or by how much is the unanswerable question.

There is certainly a temptation to jump immediately onto the internet trading bandwagon in order to prevent being left behind. However, it is a sobering thought that, while in a recently published list of the country's richest under 30s the new breed of e-commerce entrepreneurs dominate, it is those who supply services to the internet and not those who trade who are reaping the rewards.

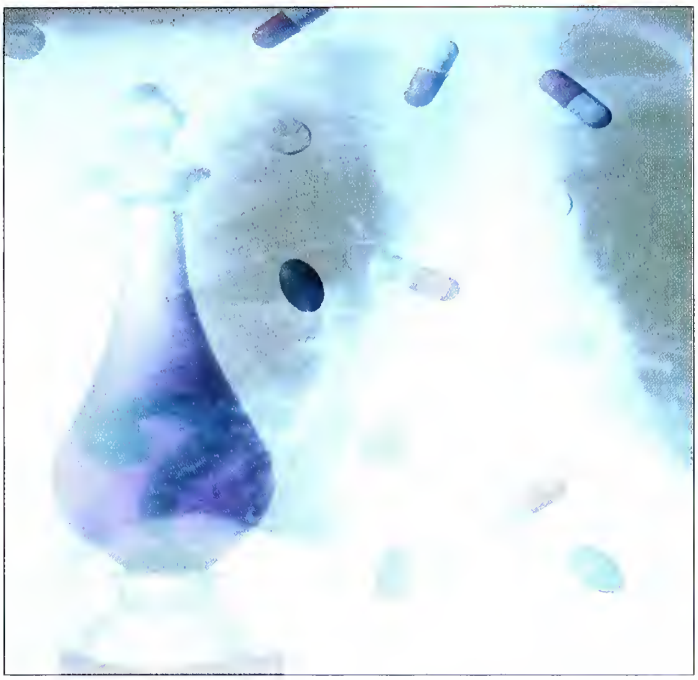
I am certain that achieving profitable trading on the internet will be a long and painful process with traditional retail shops fighting every inch of the way to maintain their customer base.

Some will be more susceptible to electronic competition than others, but real community pharmacies will always have the advantage over their virtual rivals of the personal service, accessibility and immediacy of service that no 'mail order' system can ever provide.

However, it is also true that e-commerce is here to stay, and having decided to remain in the real world I have now to decide how I can use its facilities to my best advantage.

And the first lesson to be learned is 'don't panic'. Last week's issue of *C&D* was dominated by internet information, both in its special feature on 'Information Technology' and in the **Business News** pages. They provided me with an ideal overview of the position to date. The speed of change may be breathtakingly fast but the fog is at last beginning to clear.

As an information source the internet will become an invaluable tool that will quickly replace all those instantly out-of-date reference books. As a trading tool it will allow me to compete for on-line business through my membership of a centrally organised web site along the lines of that suggested by Vijay Mehta in his letter to the NPA.



The electronic prescription will come and will be a positive benefit to patients once the very real problems of true freedom of choice have been overcome.

And for the independent pharmacist, the catalyst for all this change must be the National Pharmaceutical Association. It is the only pharmacy organisation with a strong enough mandate to act on behalf of us all and the only one to have the proven organisational structure necessary to face the challenges of the electronic market place.

The Association has already 'dipped its toe in' with the NPA intranet but must now go further and quickly develop quality professional and commercial web sites that no member of the NPA can afford not to subscribe to.

Diabetic patients highlight a problem at the interface

I recently criticised doctors, and by implication GPs, for not giving me prior warning of when they were switching diabetic patients to 3ml cartridges from 1.5ml or 10ml vials. Now I have rightly been admonished by Mary Weatherstone (**Letters**, *C&D* March 11) for blaming the GP when, in fact, the real problem is the lack of communication between hospital diabetic clinics and GPs.

It seems that I am in the same boat as the GP, but I do suffer more from motion sickness. The change of cartridge size may cause wastage of already prescribed insulin and therefore may adversely affect a GP's prescribing budget but it affects me directly. I am forced to throw away every no-longer-used insulin vial that goes out of date, and that has a painful effect on the contents of my wallet!

However, I do accept that, contrary to what I suggested, the GP may not be in a position to easily rectify the problem since it is at the secondary/primary care interface that communication is once again lacking. So here is a problem that should perhaps be raised at primary care group level.

It is unlikely that the hospital trust will respond to suggestions from individual GPs or pharmacists, but they might be more amenable when the approach is made through the PCG. After all, local accountability is at the core of the PCG concept and a combined GP/pharmacist request is such a novel event it should produce immediate results!

Taking the NHS away from government

The NHS Executive should be separated from government and run as a non-departmental public body, in a similar way to the Bank of England. Primary, secondary and self-care facilities should be brought together locally within a new setting - the community resource and treatment centre - where specialist facilities would provide a more accessible alternative to hospital outpatient clinics.

These are among the proposals in a discussion paper published by the NHS Alliance, which represents primary care groups. It recommends that, at defined intervals, the Government should describe explicitly the service it aims to finance and then negotiate the provision of that service with the NHS Executive and its delivery organisations.

A national advisory body would recommend to the Government what should be specified; members would be drawn from expert organisations such as the National Institute for Clinical Excellence, together with health and social care professionals, politicians and the public. The cost of services would be negotiated with the NHS Executive.

The agreement would reflect the public's priorities and whether people would be prepared to pay more through taxation for additional services. Patient groups would be consulted about the quality indices they felt were most appropriate to their condition, which would be incorporated into clinical governance.

"It would also distance politicians from the day-to-day turbulence of service operation," the discussion paper says.

At local level there would be explicit public negotiation by the primary care organisation of the services to be provided within the budget. An annual accountability agreement, reflecting national imperatives and local need, would identify what could and could not be provided with the available resources.

As service frameworks increasingly defined what was available, GPs would have less direct responsibility for resource management. Compliance with agreed clinical pathways would be monitored by audit, and incentives would reflect demonstrable improvement in clinical care rather than financial underspends.

The document 'Implementing the vision: maintaining the values' is available to non-members for £21 including postage, from the NHS Alliance (tel: 01737 869080).

Illicit drug use in teenagers reaches nine-year low

Illicit drug use among teenagers is at its lowest for nine years, according to a study.

The annual survey of 40,000 school pupils in the UK revealed that drug usage among teenagers peaked in 1995-6, and has since stabilised or may even have fallen. 'Young people and illegal drugs' by the Schools Health Education Unit found that 21 per cent of 14-15-year-olds have tried an illegal drug at some time.

It found 39 per cent of 14-15-year-olds know where to obtain an illegal drug and 58 per cent are fairly sure or certain they know a drug user. Almost half have been offered an illegal drug at some time.

More than 60 per cent of children aged nine to 11 would like their parents to talk to them about illegal drugs. More than 30 per cent would prefer the talk to come from teachers.

Taking drugs with alcohol is more widespread than taking two different drugs together. About 15 per cent of 14-15-year-olds have taken drugs and alcohol together, while the figure for those who have taken drugs in combination was only about 5 per cent.

People now less concerned about AIDS ... and suntans

People are becoming less interested in getting a suntan and are less likely to change their sexual behaviour because of AIDS.

The 1998 Health Education Monitoring Survey showed that 74 per cent of adults had not changed their behaviour because of concern over AIDS, compared with 67 per cent in 1995. Using a condom was the main change in 1995 (13 per cent), compared with 9 per cent in 1998, when the main change was sticking to one partner (10 per cent).

The condom remains the most popular method of contraception among adults aged 16-54 who first had intercourse in the previous five years - it was used by 69 per cent of those surveyed in both 1998 and 1995. In 1998 27 per cent had used oral contraceptives (19 per cent in 1995) and 5 per cent the morning-after pill (4 per cent in 1995). The numbers thinking they were at low or no risk of contracting a sexually transmitted infection remained constant at 85 per cent.

Having a suntan was important to 16 per cent of men and 24 per cent of women in 1998, compared with 23 and 32 per cent respectively in 1995. Men were more likely than women to have been sunburnt in the past 12 months - 28 per cent in 1998, compared with 20 per cent. Three years previously the percentage of men getting burnt was 2 per cent lower and women 2 per cent more.

Overall, using suncream was the most frequently cited way to reduce the risk of skin cancer, but older age

groups were more likely to suggest staying in the shade.

In 1998, 22 per cent of men and 26 per cent of women reported 'less than good' health. As expected, the percentages reporting poor health increased with age. Poorer health was also greater in the manual social classes on low incomes, those with no educational qualifications and those in local authority housing.

Twenty-four per cent of men and 29 per cent of women reported having suffered a large amount of stress in the previous year. Stress peaked in those aged 35-44, where about one-third reported being affected. Stress was higher among men and women who were widowed, divorced or separated, those in social classes I/II, those with annual household incomes less than £10,000 and those in local authority housing.

Men were more likely than women to smoke (29 per cent compared with 26 per cent) and men were more likely to be heavy smokers. Younger people were more likely to smoke (39 per cent of men aged 16-24), and smoking was more prevalent in social classes IV/V and those with low incomes.

Just over a quarter of men (27 per cent) and 35 per cent of women were classified as sedentary - participating less than once a week in 30 minutes or more of moderate intensity activity. Only 17 per cent of men and 6 per cent of women took part in vigorous physical activity lasting 20 minutes or more at least three times a week.

When it came to diet, 21 per cent of men claimed they ate a less healthy diet compared with 16 per cent of women, while only 12 per cent of men reported eating healthily compared with 17 per cent of women. Healthy eating was more prevalent in the middle age groups than among the young and old.

The results of the survey, carried out by the Office for National Statistics, are published in 'Health in England 1998: investigating the links between social inequalities and health' (HMSO, £32.50).

PharMed to start advisory implementation group

Electronic prescription developer PharMed is to set up an advisory implementation group to replace its advisory panel.

This new group will look at issues surrounding the use of electronic prescribing systems in 'real' environments. It will comprise two Early Adopter representatives, system suppliers using PharMed interfaces and four further members of the PharMed Early Adopter programme.

The change has come about following the NHS Executive's decision last year to set up a working party to look at the specification for a national Electronic Transmission of Prescriptions system prior to procurement. Several of the organisations on the PharMed Advisory panel were asked to join the working group, so have withdrawn from the PharMed group to avoid conflict of interest clashes.

16-17 APRIL 2000 GRAND HALL · OLYMPIA

natural products europe

LONDON

2000

"For anyone interested in the future of the pharmacy sector, *Natural Products Europe* is the best place to find out what's happening - the natural remedies and supplements category already represents a significant part of our turnover"

ZAYD MAHFOOTH
owner,
Spatetree Pharmacy
London

What's on at the Show?

- vitamins
- supplements
- herbals
- bodycare
- aromatherapy
- sports nutrition
- homoeopathy
- organic products
- eco products
- seminars
- organic catering

THE INTERNATIONAL TRADE SHOW

NATURAL & ORGANIC

FOR NATURAL & ORGANIC PRODUCTS

for FREE fast track ticketing call 01903 817307 or register online at www.naturalproducts.co.uk

Script specials

Sonata for 'severe' insomnia

Sonata (zaleplon) is the first in a new class of non-benzodiazepine hypnotics indicated for the short-term treatment of severe or distressing insomnia. Lundbeck and Wyeth have launched Sonata as part of a joint company venture.

Zaleplon, a pyrazolopyrimidine, is indicated only in insomnia that is severe, disabling or is causing the patient extreme distress. It is recommended for people who have difficulty falling asleep and is unsuitable for those who have early morning awakening. Treatment should be as short as possible with a maximum duration of two weeks.

Zaleplon has a rapid onset of action - working within 30 minutes of administration - and a short half-life, which means it can be taken any time during the night as long as there are four hours' sleep remaining. Other non-benzodiazepine hypnotics normally have to be taken at bedtime.

Zaleplon's short half-life and its ability to maintain normal sleep architecture means the next-day hangover effect is comparable to placebo and is much less than with other hypnotics. Memory function, psychomotor skills or reaction time are not impaired even when the drug is taken four hours before waking. However, care should still be taken if driving or operating machinery.

The incidence of rebound insomnia and other symptoms of withdrawal are low and not significantly greater than with placebo.

The recommended dose is 10mg at night (5mg for elderly patients). Patients must not take more than one dose in one night. Loss of efficacy may occur after a few weeks.

The drug is contra-indicated in severe hepatic impairment, sleep apnoea syndrome, myasthenia gravis, severe respiratory insufficiency and in patients under the age of 18. Zaleplon should also be used with extreme caution in people with a history of alcohol or drug abuse. Concomitant use with alcohol is not recommended.

Sonata comes in two strengths: 10mg (14 capsules, £3.36) and 5mg (14, £2.80).

Lundbeck Ltd. Tel: 01908 649966.

Trileptal: new first-line treatment for epilepsy

Trileptal (oxcarbazepine) is a new first-line treatment for partial seizures in epilepsy.

Trileptal is indicated for partial seizures with or without secondarily generalised tonic-clonic seizures. It can be used as mono- or adjunct therapy in adults and children aged six and over.

The new treatment is aimed at newly diagnosed patients and the 30-50 per cent of diagnosed patients who are poorly controlled with current therapy. Oxcarbazepine has been shown to be better tolerated than older standard first-line treatments with fewer dose limiting side effects, which means higher doses can be used to control seizures. The drug, which has been available in over 30 countries since 1990, is also associated with lower discontinuation rates and fewer drug-drug interactions.

Oxcarbazepine has a convenient twice daily dose frequency. The doses used vary according to whether the drug is being used alone or as adjunct therapy (see Summary of Product Characteristics [SPC] for more details). Doses should be adjusted for patients with compromised renal function. No adjustments are needed with mild to moderate hepatic impairment.

Patients with hypersensitivity to carbamazepine may experience similar effects with oxcarbazepine and in such cases treatment should be withdrawn immediately. The new drug may also render hormonal contraceptives ineffective and may potentiate the drowsy effects of alcohol. Interactions with calcium antagonists, lithium, mono-amine oxidase inhibitors and other anti-epileptics are outlined in the SPC. As with all anti-epileptic drugs, oxcarbazepine should be withdrawn gradually where possible to minimise the potential of increased seizure frequency.

Trileptal comes in three strength tablets: 150mg (50, basic NHS price £10), 300mg (50, £20) and 600mg (50, £40).

Novartis Pharmaceuticals UK Ltd. Tel: 01276 692255.

Dysport helps in spasticity

Dysport botulinum toxin injection can now be used to help children with cerebral palsy become more mobile.

In spastic cerebral palsy the affected muscles are permanently tensed and the limbs become abnormally twisted. Movement is stiff and jerky.

Botulinum toxin acts as a muscle relaxant by preventing release of acetylcholine at nerve endings. Within 12 to 72 hours of the injection, the muscles become less rigid and movement is easier. A child who was unable to put his or her heel on the floor may be able to walk naturally. The effect lasts three to six months as new vesicles of acetylcholine start to form at nerve endings.

Dysport is given by intramuscular or subcutaneous injection, in an initial recommended dose of 30 units per kg body weight, divided between two calf muscles. It is usually given under a local anaesthetic in an outpatient setting, although general anaesthesia may be needed for deep muscles in some children. The maximum dose is 1,000 units (2 x 500 unit vials, £329.48 basic NHS).

Speaking at a press briefing last week, Dr Bipin Bhakta, consultant in rheumatology and rehabilitation, St James' University Hospital, Leeds, said botulinum toxin was a potent neurotoxin but could be beneficial if the right amount was used in the right place. The key was to achieve a balance between muscle overactivity and weakness. Best results were obtained in childhood before muscles or tendons became permanently shortened. Dysport should be used along with other treatments, such as physiotherapy and orthotics.

Previously Dysport was licensed for use in torticollis, squint and facial spasms. This latest licensed indication is the treatment of dynamic equinus foot deformity, due to spasticity, in ambulant children of two years of age and older with cerebral palsy.

Ipsen Ltd. Tel: 01628 771417.

MEDICAL MATTERS

Poor compliance with oral hypoglycaemics

Two-thirds of people with type 2 diabetes do not adhere to their prescribed oral hypoglycaemic treatment and compliance is even worse in those taking more than one drug, a study has shown.

The study, carried out at the University of Dundee, followed up all people in Tayside with type 2 diabetes (about 3,000) who received a prescription for more than 12 months during a three-year period. Adherence was better in patients on one-a-day treatments, although only 31 per cent of the patients on sulphonylurea alone and 34 per cent on metformin alone adhered to their medication regimen.

Those taking combined sulphonylurea and metformin showed dramatically reduced adherence at 13 per cent. Adherence was also better in those with diabetes of shorter duration and in less socially deprived individuals.

Reporting the results at the British Diabetic Association's annual conference this week, the researchers suggested pharmacists could help compliance by encouraging simple treatment regimens, good patient education and regular monitoring.

The study was population-based, which meant it had the benefit of looking at all patients in the area rather than a specially selected sample.

"The results show what is happening in the real world of day-to-day diabetes management, rather than what happens in clinical trials," said Dr David McNaughton, research pharmacist at the university. "The study confirms what pharmacists in the community have been aware of for a long time."

Multi-drug therapy was often the preferred medical choice as it was more effective, but patients found it more difficult to adhere to, he added.

THIS SUMMER, WE'RE DOING SOMETHING REALLY RADICAL. WE'RE SPENDING LOADS OF MONEY ON TV AND RADIO.

This year's Zirtek campaign will be even bigger and better than last year. We're spending more money on television - to promote Zirtek to your customers at peak viewing time. And we're going on radio as well - advertising at key times on popular commercial stations.

We'll still be sponsoring GMTV's pollen forecast. But this year we'll also be sponsoring the National Pollen Research Unit's web site.

Furthermore, there's a distinctive new pack design, eye-catching point of sale materials and extensive promotion to GPs.

It all adds up to a marketing spend of £2 million. In fact, it all adds up to a big year for Zirtek. So make sure you're in a position to take advantage.

ONE · A · DAY

Zirtek™

ALLERGY cetirizine

NOTHING HITS HAYFEVER HARDER

ZIRTEK ALLERGY
PRESENTATIONS: White, oblong, scored, film-coated tablet engraved Y/Y containing 10mg cetirizine hydrochloride.
USES: Treatment of seasonal and perennial rhinitis and chronic idiopathic urticaria.
DOSAGE AND ADMINISTRATION: Adults and children aged 6 years and over: 10 mg once daily. In renal insufficiency halve the dose to 5 mg (½ tablet) daily.
CONTRAINDICATIONS: Hypersensitivity to constituents. Avoid use in pregnancy and lactation.
PRECAUTIONS: Do not exceed recommended dose, particularly if driving or operating machinery.
DRUG INTERACTIONS: To date there are no known interactions with other drugs. As with other antihistamines avoid excessive alcohol consumption.
SIDE EFFECTS: Mild and transient drowsiness, headache, dizziness, agitation, dry mouth and gastrointestinal discomfort have been reported.
PACKING, PRICE: Pack of 7 tablets = £4.25 Retail.
LEGAL CATEGORY: P
PRODUCT LICENCE NUMBER: Tablets 5221/0001.
MARKETED BY: UCB Pharma Limited, Watford, Herts. WD1 8UH.
For further information please contact: UCB Pharma Limited, UCB House, 3 George Street, Watford, Herts. WD1 8UH.
Telephone (01923) 211811. Facsimile (01923) 229002.
Date of preparation: March 2000.
UCB-Z-00-03

ucb Pharma

Counterpoints

Get plastered for fast and natural healing from Robinson Healthcare

Robinson Healthcare is launching an advanced new plaster range for minor injuries at home or on the sports field.

Quick2heal plasters are designed to create an environment that wounds can heal in quickly and naturally. Left in place for three to seven days, the plasters control the moisture level in the wound.

Robinson Healthcare says that because the dressings allow moist wound healing to take place, this should mean that healing is up to 50 per cent faster, and there should be less pain and less scarring.

The range includes three products – transparent film plasters for grazes, friction burns and sore areas; skin closures with transparent film plasters for deeper cuts; and ultra-absorbent plasters for cuts, blisters and minor burns.

The plasters are hypo-allergenic and waterproof. Retail prices range from £3.49 to £3.99.

Robinson Healthcare.
Tel: 01246 505450.

Bonus offer for Rhinolast Hayfever

ASTA Medica's Rhinolast Hayfever antihistamine nasal spray is now being marketed by AHA Sales Services.

AHA has taken over the UK sales, marketing and promotion of the product. Rhinolast Hayfever contains azelastine hydrochloride and is formulated for the treatment of seasonal allergic rhinitis.

As an introductory offer, AHA is promoting the product with a special bonus offer for the independent pharmacy sector.

AHA Sales Services Ltd.
Tel: 01491 833202.

Hay fever relief for your nose

Thornton & Ross has launched a new Hayfever Relief Nasal Spray under the Care label.

Hayfever Relief Nasal Spray contains beclomethasone dipropionate in a bottle of 200 metered sprays (rsp £5.49). The treatment is suitable for sufferers over the age of 18 years.

The new launch will be supported by PoS and launch discounts.

Thornton & Ross Ltd.
Tel: 01484 842217.

Comodynes are set to wipe up in teen skincare market

Perma-Jeune is expanding its Comodynes range with new cleansing and treatment facial wipes targeted at teenagers and young adults who have blackheads and pimples.

Comodynes Dermatological wipes are formulated to deep cleanse the skin while helping to reduce the excess oil secretion of the sebaceous glands and preventing the appearance of new pimples.

Designed to be quick and easy to use, the wipes are made from viscose fibres, which are impregnated with active ingredients.

Available in resealable packs, the facial wipes are hypo-allergenic and suitable for all skin types. The retail price for a pack of 20 is £3.95.

A special counter merchandiser is available from the company for in-store display.

Perma-Jeune Ltd.
Tel: 020 7580 6900.

A fresh look for Actomite

Ceuta Healthcare is introducing a new look for its Actomite treatment for house dust mite control.

The product has an eye-catching new pack design with bright red and blue graphics. It comes in an automatic diffuser aerosol spray and can be used to treat an entire room by spraying directly onto soft furnishings and mattresses.

Endorsed by the National Asthma Foundation, Actomite is designed to offer long-term relief to sufferers of asthma, eczema and other allergy-induced symptoms.

Each application will destroy house dust mites and their larvae and eggs. The treatment is effective for 12 weeks and if the product is re-applied every 12 weeks, the build up of further allergens can be prevented.

It retails at £12.99 for 400ml.

Ceuta Healthcare Ltd.
Tel: 01202 780558.

Frontline service

The Miles Group's new Frontline sales operation is supporting three pharmacy products on behalf of Passion for Life Products.

The brands are Wartner – a Dutch treatment for warts and verrucae, Snorenz and Breath Buddies. Other brands available from the Frontline sales force are BR Pharmaceuticals' Valupak and Reveal, and Masterspare's Copper Comfort.

Frontline.
Tel: 01484 850707.

When a cold sore attacks, target your customers with soothelip

Soothelip offers maximum protection for cold sores at an affordable price for your customers.

Unlike other treatments, Soothelip has always contained dimethicone to provide a protective soothing barrier that will gently moisturise lips.

And because Soothelip's formulation is quickly absorbed, nothing you can recommend works faster or better.

Recommend

Nothing works better to heal and soothe cold sores.

PRODUCT INFORMATION: Soothelip For Cold Sores: contains 5% of aciclovir in a smooth white to off-white cream. It also contains: cetyl alcohol, dimethicone, heavy liquid paraffin, polyethylene glycol – 5 glyceryl stearate, propylene glycol, sorbic acid, white soft paraffin and water. **Indications:** the treatment of infections caused by the herpes simplex virus, such as cold sores. **Dosage and Administration:** cream should be applied to the affected area five times daily about every four hours for five days. If the cold sore has not healed after five days, treatment may be continued for a further five days. If the cold sore has not healed after ten days or gets worse during treatment, a doctor should be consulted. **Precautions and Warnings:** Patients should be advised to seek the advice of a doctor before taking Soothelip if: they are pregnant, plan to become pregnant or are breast feeding, if they are allergic to any of the ingredients in the cream, or if their immune system is not working properly. Soothelip should not be used for herpes infections of the eye, inside the mouth or genital areas. **Product licence number:** 0142/0426. **Licence Holder:** Cox Pharmaceuticals, Barnstaple, EX32 8NS. **Sold and Distributed in the UK by:** Bayer plc, Bayer House, Strawberry Hill, Newbury, Berkshire, RG14 1JA. **Legal Category:** P. **Date of preparation:** February 1997.

This way for Commercial Support.

Pharmacy Finance. Locum Cover. Energy Supply. UniChem provides independent pharmacists with help and advice in these and many other areas that are crucial to the running and success of any business.

We recognise that today's busy pharmacist often does not have the time to source the best financial advice. UniChem's Commercial Support department, through its broad spectrum of contacts, ensures that pharmacists are able to gain professional, independent advice. We also provide the assurance that, whatever your particular concern, you can speak to experts who specialise in the needs of pharmacists.

Whether you are considering finance for a new pharmacy layout, help with your own travel or life assurance policies, or need advice on accounting matters, UniChem can point you in the right direction. Our partners working with Commercial Support, are your partners. Why not give us a call on 020 8391 2323 to see how we can help.

UniChem
Delivering Healthcare

UniChem
Delivering Healthcare

SERVICE + INNOVATION + EXCELLENCE + PARTNERSHIP

UniChem Ltd., UniChem House, Cox Lane, Chessington, Surrey KT9 1SN. Tel: 020 8391 2323

Griptight brightens up meal times for babies

Lewis Woolf Griptight is adding over 20 new lines to its Griptight Savers range of baby products.

The range has been colour-coded into six different segments - bottles, teats, soothers, feedtime, rattles and toys and accessories.

New in the bright citrus coloured feedtime section is a Snack Set (three food pots and lids plus three weaning spoons), Pop-Up Travel Cups, Mother's Feeding Bowl featuring a thumb hole, and Toddler Sports Bottles with travel lids and heat sensitive weaning spoons.

Other new additions to the range include a wide neck bottle and wide neck Variaflow teats.

Retail prices range from £0.99 to £2.99.

Lewis Woolf Griptight Ltd.
Tel: 0800 614668.

Lip service from Maybelline

Laboratoires Garnier is launching a new long-lasting lipstick in its Maybelline range in April.

Maybelline Hydrastay Lip Colour has been developed to provide long-lasting, glossy colour without drying the lips.

It has a deep moisturising formula that contains vitamins A and E to leave a protective layer on the surface of the lips.

The hypo-allergenic and dermatologically tested lipstick is available in 19 fashionable shades, with fun names like Prankster, Saucy, Sexy and Siren.

The product comes in a slim-line navy blue and silver case with a high precision applicator.

Retail price is £4.49.

Laboratoires Garnier.
Tel: 020 8762 4010.

Coty plans spring launch for Margaret Astor cosmetics range in UK

Coty is planning a UK launch for its largest global colour cosmetics brand this spring.

The Margaret Astor brand will be exclusive to Boots from April and available to Superdrug from June. Coty says it may consider expanding distribution at a later date.

The brand already represents 50 per cent of Coty's turnover in the mass-market cosmetics area worldwide, with growing sales in Spain, Germany, Poland and Latin America.

David Allan, Coty UK marketing director, comments: "Our research indicates that a significant opportunity exists for a colour cosmetics brand to target slightly older women, the core being in their early 30s, who are aspirational, confident, independent and not afraid to experiment with colour."

The launch colour collection comprises 54 lip, 50 nail and 27 eye colours ranging from classic to high fashion shades.

The range is presented in matt silver packaging featuring the design signature of a transparent dome shape embossed with a daisy motif. Retail prices will range from £3.49 to £7.99.

A £5 million national television advertising and women's press campaign will support the launch from July. The commercials will feature either Margaret Astor Soft Sensation Lipstick or 60 Sec Wonderlast Nail Polish.

Coty (UK) Ltd.
Tel: 020 8971 1300.

L'Oréal expands Féria colours

L'Oréal is adding six new shades to its Féria Color permanent hair colour range in April.

The new colours include four new rich, natural brown hair shades - French Roast, Crystal Brown, Brazilian Brown and Espresso - and also two new glossy blondes: Cashmere Blonde and Pure Diamond.

Suitable for men and women, the Féria Color range now comprises 25 shades. Retail price is around £6.99.

L'Oréal Group UK.
Tel: 020 8762 4000.

IN BRIEF

In the running

Johnson & Johnson.MSD will be supporting the Floro London Morothon on April 16 with an Imodium Plus sponsorship deol. The compony hos also lounched o regionol rodio compoign in the London oreo for Imodium Plus. A series of rodio commerciols for the brond will be on oir for the next three weeks.

Johnson & Johnson.MSD Consumer Pharmoceuticols.
Tel: 01494 450778.

Philips promotion kicks off

Philips is lounching on 'instont win' on-pock consumer promotion for its Powerlife XXL botteries to tie in with the brond's sponsorship for the UEFA Euro 2000 footboll chompionship. Promotionol pocks of AA size botteries will give consumers the opportunity to win tickets ond trovel to the Euro 2000 finol. A Euro 2000 themed pre-pocked counter top disploy unit holds 40 pocks of four AA botteries.

Philips.
Tel: 020 8665 6655.

Cetraben change

Sonkyo Phormo UK is now the distributor for Phormo Heolth Core's Cetroben skincore ronge for the symptomotic relief of dry or domoged skin.

Sonkyo Phormo UK Ltd.
Tel: 0800 068 7616.

In the picture

ColourCore is to reduce the price of its 35mm Photo Index product by £0.50 from April 3. The new price of £0.49 is designed to stimulote first time soles during the peok summer seoson.

ColourCore Internotionol Ltd.
Tel: 01722 412202.

ON TV NEXT WEEK

Clearblue Home Pregnancy Test: G, A, W

Gillette Mach3 razor: All areas

Movelat Relief: B, G, A, HTV, M

Nicorette: All areas

Niquitin CQ: All areas except U, CTV, GMTV

Nytol: All areas

Propain: B, G, M, LWT, TT

Radox Showerfresh: GMTV, ITV, C5, Sat

Setlers: All areas

A Anglia, **B** Border, **C** Central, **C4** Channel 4, **C5** Channel 5, **CAR** Carlton, **CTV** Channel Islands, **G** Granada, **GMTV** Breakfast Television, **GTV** Grampian, **HTV** Wales & West, **LWT** London Weekend, **M** Meridian, **Sat** Satellite, **STV** Scotland (central), **TT** Tyne Tees, **U** Ulster, **W** Westcountry, **Y** Yorkshire

Something for nothing?

Referring back to **Xrayser**'s comment on the Southern Derbyshire out-of-hours emergency on-call scheme (*C&D* 29 January, p7), may I, having been involved for the past 15 years in operating an out-of-hours call-out system, add my comments?

The Derbyshire Royal Infirmary has always endeavoured to obtain an NHS contract, and one of the methods was to state that it was inundated with prescriptions out of hours. The LPC obtained a set of statistics and found that some of the prescriptions presented, dispensed and then paid for by the Health Authority (FHSA), although not legal, were in fact dispensed during normal business or rota hours.

With great trouble, spanning two to three years, we managed to get Derby police involved, but there were problems, both from the police and the non-availability of pharmacists.

When we acquired a new chief executive at the HA, we asked, tongue in cheek, for funding for a police call-out with the guarantee of pharmacist availability. Although it took 12 months to get off the ground due to the need of protocols etc, it started, and surprise, surprise, the number of urgent items is almost identical to the numbers generated by the DRI some 12 years ago (excluding syringe drivers).

What I find is that **Xrayser** wants a vast amount of cash for being called out, and has never been involved in a voluntary call-out system. No doubt **Xrayser** dispenses monitored dose systems to homes for nothing, does domiciliary visiting for nothing, pre-payment certificates for nothing and was critical of an LPC who has at least got something on the stocks and is getting something locked into a contract.

Come on, **Xrayser**, spill the beans. What do you do for nothing, and if not, what are you doing about getting involved to get something?

Rodgers F Jefferies
Secretary, South Derbyshire LPC

We need action!

While we are in agreement that the ethos of Council members is to work within the interests of patients, the profession and for pharmacists, I find Mr Nathan's account of the changes made within Council (*C&D* March 4, p24) highly peculiar. It also seems that not only do we have a father of the Council in Bill Darling, but now we seem to have Alan Nathan as a self-elected lord chief justice! I apologise for having to respond publicly, but three points have to be raised.

1. For the record, many members of our hard working profession were not happy with Council; they felt let down, betrayed and unrepresented by an out-of-touch establishment. The problem was so deep rooted that it needed something radical to bring Council up to date and in touch with its grass roots.

That radicalism started publicly when Hemant Patel was elected as president, and although no one person is responsible for the old culture or the new one, it caused major repercussions, which in my opinion were beneficial, as Council needed a good shake-up. It was traumatic, but it was necessary and life saving. That rift that Mr Nathan criticises has resulted in an increase in Lambeth's probity, and has made Council more accountable.

And the main reason for introducing these much needed fundamental changes was to heal the disquiet among a sizeable number of Council members. If he does not put them down to the Council rift, I would like to know why so many changes were made recently – he has been on Council for the past 13 years.

2. Mr Nathan's 'holier than thou' article champions corporate governance, but in the truest sense of this it follows that any PR relating to Council should be addressed via official channels. Yet by electing himself as Council prefect he obviously does not practise what he preaches and the cliché 'Do as I say not what I do' comes to mind. Surely it is up to the grass roots members to decide who is truly representing them – one of the recent decisions made was to highlight and audit the Council members' attendance records etc.

3. Alan Nathan says that some Council members seem to be unable to put the interests of the profession before their 'narrow sectional' interests. Surely these 'interests' are sizeable and important enough to get those members of Council elected.

It goes without saying that team working and understanding broader issues is very important, but having a representative voice on decisions made cannot be ignored. What is Mr Nathan suggesting? Ignore the members? Say anything to get elected and then ignore the electorate? Another criticism made is that, once elected, certain Council members are not heard of again or that Council is not representative. Does he condone this?

Recorded votes and an official hustings are on the agenda, something I hope Mr Nathan will support. Meanwhile we don't need sanctimonious acts of self grandeur, we need action.

With that said I am sure we could all look forward to working with him on Council to further improve on the structures in place, and to increase the probity, accountability and transparency on Council to allow its members to progress the profession. Until then, to use Mr Nathan's quote, 'I intend to maintain a watching brief'.

Sid Dajani
RPSGB Council Member

PHARMACYupdate

Hard evidence

Primary care pharmacist Dr Rod Tucker explains what evidence-based medicine is and how it can be used by pharmacists to develop their pharmaceutical role

THE COLLEGE OF PHARMACY PRACTICE

THIS COURSE (MODULE 1157), IN ASSOCIATION WITH MULTIPLE CHOICE QUESTIONS BEING PUBLISHED IN *C&D* APRIL 8, PROVIDES ONE HOUR'S CONTINUING EDUCATION

OBJECTIVES

- To understand the importance of evidence-based medicine
- To understand what it means in practice
- To be aware of how to interpret evidence
- To be aware of how evidence can be implemented
- To be able to use EBM in normal practice

Providing the patient with the most appropriate treatment to relieve their symptoms or treat their condition has always been the essential function of the physician. When deciding on a particular treatment physicians have traditionally drawn on their own experience or that of other colleagues, and this practice has worked very well.

However, the importance of randomised controlled trials has been recognised since the Second World War. Today, there is increasing pressure for prescribing decisions to be based on the results of good quality clinical studies. This change of emphasis reflects an increasing awareness of the concept of evidence-based medicine (EBM). This term is defined as "the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients"[1]. Practising EBM involves making best use of the current clinical evidence to treat a particular condition and combining this with clinical expertise that is based on experience and knowledge of the patient.

Why evidence-based medicine?

In 1997, the government White Paper 'The new NHS: modern, dependable' envisaged a new NHS system that would deliver better healthcare for patients. In order that the money spent on prescribing can be used more effectively, treatment provided by doctors should be based on the results of good clinical evidence so that patients can obtain maximum benefit from a particular therapy.

If doctors do not prescribe treatment that is proven to be effective, then resources could be wasted and, more importantly, other patients might be deprived of treatment. With the arrival of primary care groups (PCGs) and a cash limited budget which includes prescribing, there are strong incentives for the PCGs to ensure that prescribing is cost-effective. In addition, the emergence of clinical governance should ensure that prescribing is of the highest quality and, wherever possible, evidence-based. The current inequalities in healthcare, shown, for instance, by 'post-code' prescribing, should be resolved in time by the new National Institute for Clinical Excellence (NICE).

NICE will also work to produce evidence-based guidelines and National Service Frameworks which should ensure that access to services and the quality of the services provided throughout the NHS are consistent.

Continued on PII →

Continued from PI

Understanding the evidence

The 'gold standard' evidence comes from randomised controlled trials (RCTs). However, often such good quality studies do not exist and lower levels of evidence must be sought. The different levels of evidence are graded as shown in Box 1.

One of the greatest problems for doctors who use clinical trial-based evidence in practice is that two RCTs might produce conflicting results, which clearly make treatment decisions more difficult. In the past, such dichotomies might have been resolved by seeking a review article by an acknowledged expert in the particular speciality. For the purposes of an evidence-based approach, such expert reviews are relegated to a lower level of evidence (see Box 1) since their conclusions can be subjective and there is no way that the reader can determine whether or not the reviewer has included all the relevant studies.

The narrative reviews have been largely replaced by systematic reviews and meta-analysis. A systematic review is a rigorous approach to determining the answer to a specific question. Once the question has been defined, the medical literature is searched and assessed using pre-defined criteria, and all the results are combined and then placed in context.

This latter point is important since the review will discuss the quality of the studies included and the applicability of the results obtained.

Systematic reviews are produced by organisations such as the Cochrane Collaboration, the NHS Centre for Reviews & Dissemination and others (see Box 2).

A meta-analysis is effectively a quantitative systematic review which combines the results of individual studies to provide a weighted average measure of the treatment effect, hence avoiding any possible conflicts produced by different RCTs.

A meta-analysis is, therefore, analogous to having a single study with a very large population that includes a range of different patients. While there are advantages to the meta-analytical approach, there are some potential disadvantages.

It has to be asked whether the analysis included all possible studies and, since individual studies often use different outcome measures and even different types of patients, there is a question as to the validity of combining such results. This variability in a meta-analysis is termed heterogeneity and is an accepted limitation. Nevertheless, a high degree of heterogeneity can compromise the validity of the meta-analysis.

The other main potential disadvantage is that the quality of the studies involved in the meta-analysis will clearly influence the conclusions reached, thus the GIGO (garbage in, garbage out!) principle applies.

For health professions to make effective use of EBM, a clear understanding of the language and terminology is essential but, unfortunately, this is an area that has produced much confusion among doctors, healthcare managers and patients alike. It is, therefore, necessary to define and explain some of the important concepts in EBM.

Box 1 – Categories of evidence (adapted from reference 6)

Ia: Evidence from meta-analysis of randomised trials
Ib: Evidence from at least one randomised controlled trial
IIa: Evidence from at least one controlled study that is not randomised
IIb: Evidence from at least one other type of quasi-experimental study
III: Evidence from non-experimental descriptive studies, eg comparative studies, case controlled studies
IV: Evidence from expert committee reports or opinions and clinical experience of respected authorities

Box 2 – Various internet evidence-based medicine sites. Note that these sites also have links to other medical sites

NHS R&D Centre for evidence-based medicine:
http://drsdesk.sghms.ac.uk/Starnet/atoz.html

Centre for Reviews and Dissemination (CRD):
http://www.york.ac.uk/ins/crd/welcome.html

Cochrane Library home page:
http://www.cochrane.co.uk

Bandolier:
http://www.jr2.ox.ac.uk/bandolier

PubMed – free medline:
http://www.ncbi.nlm.nih.gov/Pubmed/

Anglia & Oxford Healthcare library unit:
http://www.lib.jr2.ac.uk/otherinf.html

Box 3 – Calculation of EBM parameters [data from CARE study (5)]

Treatment	Outcome after trial (five years)		Total patients in each arm of trial
	Dead	**Alive**	
Pravastatin 40mg	212	1,869	2,081
Placebo	271	1,804	2,078

If the risk of dying after five years without pravastatin is x, then,
x=271/2,078 = 0.132
(13.2 per cent)

If the risk of death after five years with pravastatin is y, then,
y=212/2,081 = 0.101 (10.1 per cent)

The relative risk of death = y/x (0.101/0.132) = 0.77

The relative risk reduction = (x – y/x) X 100 = 23 per cent

The absolute risk reduction = x – y = 0.132 – 0.101 = 0.031

The event free survival is the percentage surviving after five years rather than dying. Thus for pravastatin = 1,869/2,081 x 100 = 89.8 per cent and for placebo = 1,804/2,078 x 100 = 86.9 per cent

The odds of death in the pravastatin group is
212/(2,081 – 212) = 0.113
The odds of death in the placebo group is
274/(2,078 – 274) = 0.151

The odds ratio = 0.113/0.151 = 0.75

The number needed to be treated to prevent one death is the reciprocal of the absolute risk reduction, ie 1/0.031 = 33

Understanding the results

The main objective of the pharmaceutical industry and its representatives is to convince doctors that their particular product is worth using. In order to achieve this, most company representatives have traditionally relied on glossy sales aids showing large reductions in events or greater control of symptoms by their drug compared to a competitor's product.

This approach is based on the old idea of 'the bigger the better'. In other words, if the numbers are large, doctors are more likely to be impressed and so more likely to prescribe the product. This theory has been tested in several studies. In one such study[2] the researchers set out to determine if the manner in which results were presented to a group of health authority purchasers would influence their decision to implement one of four cardiac rehabilitation programmes (shown below) given that the costs of introducing each service were the same after a three year follow-up.

- Programme A reduced the rate of death by 20 per cent.
- Programme B produced an absolute reduction in deaths of 3 per cent.
- Programme C increased the rate of patient survival from 84 to 87 per cent.
- Programme D meant that 31 people needed to enter a rehabilitation programme to prevent one death.

The results showed that most health authority purchasers were willing to fund programme A. Similar preferences were found when physicians were asked to prescribe treatment for hypercholesterolaemia and hypertension[3]. In other words, larger numbers seem to exert more influence than smaller numbers, whereas the four different programmes listed above come from the same study and are simply different ways of presenting the data.

The various ways in which results are described are illustrated in Box 3 using the CARE study with pravastatin.

- **Relative risk** simply expresses the risk of the event relative to the alternative, ie pravastatin compared to placebo. If the relative risk is 1, then there is no difference in outcome between the drug and placebo. When the relative risk is greater than 1 there is a greater risk attached to using the drug compared to the placebo. Conversely, if the relative risk is less than 1, the risk associated with the drug is less than that for the placebo. For example, in Box 3, the relative risk is 0.77, this

Continued on PIV →

For when life becomes hard to swallow...

...a product that isn't.

LOMONT™ is the only licensed oral liquid Lofepramine available to treat the symptoms of depressive illness*

- Useful when depression is accompanied by lethargy**
- Easy to swallow
- Ready to use liquid
- Helps to ensure patient compliance
- 70mg/5ml strength
- Pleasant cherry flavour
- Sugar free

* BNF March 1999 ** BMA New guide to medicines and drugs

ROSEMONT

THE SPECIALISTS IN ORAL LIQUID MEDICINES

Abbreviated Prescribing Information

Presentation: A white to off white opaque suspension with odour of cherry containing 76.1mg Lofepramine Hydrochloride, (equivalent to 70mg Lofepramine base) in each 5ml. **Uses:** For the treatment of symptoms of depressive illness. **Posology and Method of Administration:** The usual dose for adults is 70mg twice daily or three times daily depending upon patient response. Elderly patients may respond to lower doses in some cases. Lomont is not recommended for children. **Contra-indications:** Lofepramine should not be used in patients hypersensitive to dibenzazepines, in mania, severe liver impairment and/or severe renal impairment, heart block, cardiac arrhythmias, or during the recovery phase following a myocardial infarction. **Special Warnings and Precautions for Use:** Lofepramine should be used with caution in patients with cardiovascular disease, impaired liver or renal function, narrow angle glaucoma, symptoms suggestive of prostatic hypertrophy, a history of epilepsy or recent convulsions, hyperthyroidism, blood dyscrasias or porphyria. **Interactions with other Medicaments and other forms of Interaction:** Lofepramine should not be administered concurrently with or within 2 weeks of cessation of therapy of monamine oxidase inhibitors. It should then be introduced cautiously using a low initial dosage. Lofepramine should not be given with sympathomimetic agents, central nervous depressants including alcohol or thyroid hormone therapy since its effects may be potentiated. Lofepramine may decrease the antihypertensive effect of adrenergic neurone-blocking drugs; it is therefore advisable to review this form of antihypertensive therapy during treatment. Anaesthetics given during tricyclic antidepressant therapy may increase the risk of arrhythmias and hypotension. If surgery is necessary, the anaesthetist should be informed that a patient is being so treated. Barbiturates may increase the rate of metabolism. **Pregnancy and Lactation:** The safety of Lofepramine for use during pregnancy has not been established and there is evidence of harmful effects in pregnancy in animals when high doses are given. Lofepramine has been shown to be excreted in breast milk. The administration of Lofepramine in pregnancy and during breast feeding therefore, is not advised unless there are compelling medical reasons. Adverse effects such as withdrawal symptoms, respiratory depression and agitation have been reported in neonates whose mothers have taken tricyclic antidepressants during the last trimester of pregnancy. **Effects on Ability to Drive and Use Machines:** Ability to drive a car and operate machinery may be affected. Therefore caution should be exercised initially until the individual reaction to treatment is known. **Undesirable Effects:** Lofepramine has been shown to be well tolerated and side-effects, when they occur, tend to be mild. Comparative clinical trials have shown that Lofepramine is associated with a low incidence of anticholinergic side effects. The following side effects have been reported with Lofepramine: Cardiovascular; hypotension, tachycardia. CNS and neuromuscular; dizziness, drowsiness, agitation, confusion, headache, malaise, paraesthesia, tinnitus and rarely hypomania and convulsions. Anticholinergic; dryness of mouth, constipation, disturbances of accommodation, urinary hesitancy, urinary retention, sweating and tremor. Allergic; skin rash, allergic skin reactions. Gastro-intestinal; nausea, vomiting. Endocrine; rarely, inappropriate secretion of antidiuretic hormone, interference with sexual function. Haematological/biochemical; rarely, bone marrow depression including an isolated report of. agranulocytosis, eosinophilia, granuloctyopenia, leucopenia, pancytopenia, thrombocytopenia. Rises in liver enzymes have been observed in some patients usually occurring within the first three months of starting therapy. There have been a small number of reports of jaundice. These reactions are reversible on cessation of therapy. The following adverse effects have been encountered in patients under treatment with tricyclic antidepressants and should therefore be considered as theoretical hazards of Lofepramine even in the absence of substantiation: psychotic manifestations including mania and paranoid delusions may be exacerbated during treatment with tricyclic antidepressants; withdrawal symptoms may occur on abrupt cessation of therapy and include insomnia, irritability and excessive perspiration. **Overdose:** Treatment of overdosage is symptomatic and supportive. It should include immediate gastric lavage and routine close monitoring of cardiac function. Reports of overdosage with Lofepramine, with quantities ranging from 0.7g up to 6.72g, have shown no serious sequelae directly attributable to the drug. **Shelf Life:** 24 months. **Special Precautions for Storage:** Store between 4°C and 25°C. Protect from light. **Pack Sizes and NHS Prices:** 150ml – £23.64. **Instruction for Use/Handling:** Keep out of the reach of children. Shake before use. **Marketing Authorisation Number:** 0427/0094. **Marketing Authorisation Holder:** Rosemont Pharmaceuticals Ltd, Rosemont House, Yorkdale Industrial Park, Braithwaite Street, Leeds, LS11 9XE. **Date of Preparation:** June 1999

Continued from PII

means that there is a 23 per cent less chance of dying taking pravastatin compared to placebo.

- **Relative risk reduction** (RRR) expresses the reduction in risk relative to the placebo and is normally quoted as a percentage.
- **Odds ratio** is an unusual concept and expresses the odds of an event (ie dying) occurring compared to the odds of the event not occurring and odd ratios are often found in systematic reviews and meta-analysis. If the odds ratio is 1 then the odds of the event happening would be the same in both groups. If the odds ratio is greater than 1, the event (ie death) is more likely to happen in the treatment group. Conversely, if the odds ratio is less than 1 (as it is in box 3) then the odds of death is less likely in the pravastatin group.
- **Absolute risk reduction** (ARR) expresses the benefits of the intervention relative to the control group and defines the net benefit of treatment. In Box 3, there is a 3.1 per cent reduction in death in those taking pravastatin. This reduction in the risk of death is more easily interpreted as the **number needed to treat** (NNT) and is defined as the number of patients who need to be given the treatment, for the specified time interval, to avoid one of them experiencing an adverse event, ie death.

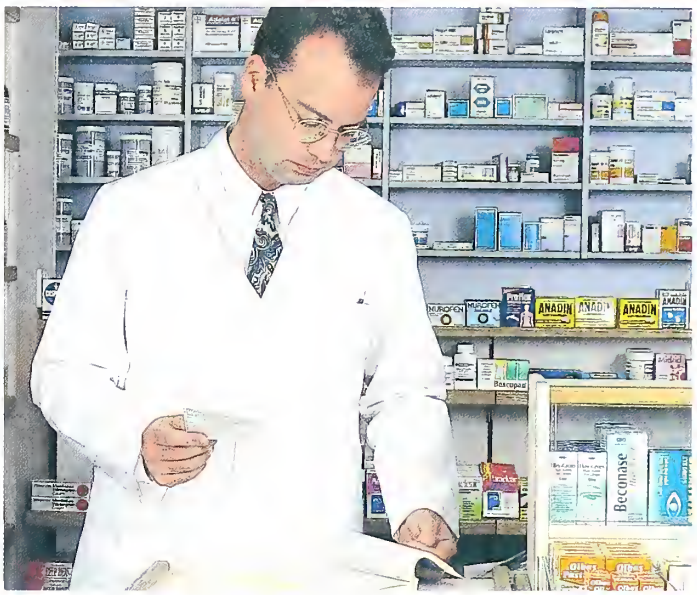
It is more important to have the ARR rather than the RRR, as the latter cannot distinguish between large and small differences in treatment effects. For instance, suppose a new drug treatment is discovered and studied in controlled trials. The end-point for the trials could be overall mortality or death. As shown in Table 1, the risk of death will vary depending on a patient's initial (ar baseline) risk level. For example, patients in trial A have a 6.6 per risk of death (these might be considered to be high risk patients) whereas in trial C, the risk of death is only 0.066 per cent (these patients are at low risk). For each trial, the RRR will be the same because the RRR defines the reduction in risk relative to the placebo. The ARR varies depending on the patient's baseline risk and as the NNT is inversely related to the ARR, the number of patients who need to receive the treatment to prevent one of them from dying increases as the ARR decreases, as is shown in Table 1.

The concepts of EBM have been pragmatically summarised by Sholbekken[4] for patients in the Scandinavian simvastatin survival study (4S study). If 100 people like you and me are given no treatment for five years, 92 will live and eight will die. Whether you are one of the 92 or one of the eight is not known. Then, if 100 people like you and me are given a certain drug every day for five years, 95 will live and five will die. Again, whether you are one of the 95 or one of the five is unknown.

Understanding and appreciating the information provided by clinical trials is important and can have a major impact on the way treatment is delivered. However, there are several other considerations to be made before treatments should be implemented.

Table 1 Hypothetical example showing how the ARR and NNT vary with the patient's baseline risk

Trial for new drug treatment	Event (death) rate (placebo) y	Event (death) rate (treatment) x	Relative risk reduction RRR = (y - x/y) x 100	Absolute risk reduction ARR = y - x	Number needed to treat NNT = 1/ARR
Trial A	6.6	4.3	35 per cent	2.3 per cent	43
Trial B	66	43	35 per cent	23 per cent	4
Trial C	0.066	0.043	35 per cent	0.023 per cent	4,347



The practice of evidence-based medicine requires the pharmacist to be up-to-date with current clinical evidence for treatment

Implementing the evidence

Evidence-based medicine provides a sound basis on which a particular therapeutic approach to treatment can be recommended. Nevertheless, the process of implementing EBM can be fraught with difficulties and there are many other factors which need to be taken into account.

Perhaps the most important factor, from the perspective of the NHS itself, is an estimate of the potential costs associated with the introduction of the new treatment, as there will always be financial restraints imposed on the health service. For example, the costs associated with implementing the SMAC guidelines on lipid lowering therapy in Warwickshire alone have been estimated to be £8m excluding the costs of monitoring treatment, diagnostic testing and the time required to identify and counsel patients[7].

No government likes to admit to rationing in the health service, preferring instead to speak in terms of prioritising services. Nevertheless, the reality is that there will never be sufficient money to meet the demands placed on the service and some form of restrictions are inevitable. This has been clearly illustrated with the debate surrounding the supply of the anti-impotence drug, Viagra. Consequently, some estimate of the costs, and hence the cost-effectiveness, is essential.

The details of how costs are determined is beyond the scope of this article but in simple terms, health economists need to explore the purported benefits of the intervention together with all the associated costs including prescribing costs, any costs of monitoring treatment, hospital costs and finally some measure of the effect of the treatment on a patient's quality of life. Trying to quantify some of these costs can be extremely difficult and in some instances best estimates and various assumptions will need to be made.

Another potential problem is that the randomised controlled trials themselves are conducted with patients who meet strict inclusion criteria and, in many instances, patients with co-morbidity are excluded. This can potentially confound the interpretation of the results, particularly in primary care where many of the patients first present with a problem. For example, the CARE study mentioned earlier excluded patients who had symptomatic congestive heart failure.

As a result, deciding whether or nat to treat a patient with pravastatin who fulfils the entry criteria for the CARE study but who also has congestive heart failure can be difficult as there is no evidence that such a patient can expect the same benefit as the patients in the original study.

Furthermore, the benefits of lipid lowering therapy occur when patients are treated for at least five years (and there is now further evidence from follow-up that the benefits are retained). Whether or not the benefits are sustained for the next ten or 20 years remains unknown.

Another problem, given the current climate of cost containment in the NHS, is whether or not the same effects can be expected to occur with another statin drug that might be cheaper. In other words, is there a 'class' effect of statin drugs? Similar concerns will apply to all evidence-based treatments.

The problem of co-morbidity can make extrapolation of RCT findings into everyday clinical practice difficult.

The difficulty for the doctar is knowing a patient's level of risk and adjusting the number to treat, using evidence from trials. This is not always easy but a possible solution has been proposed by Cook and Sackett[8] which involves dividing the absolute risk reduction by a factor which represents the patients' estimated level of risk. For example, if the baseline risk for patients in the RCT was 12 per cent and the patient's risk is only 6 per cent, then the number needed to treat would increase from eight (ie 1/0.12) to 16 (ie 1/0.06).

Despite these potential difficulties, there is now overwhelming evidence for the effectiveness of a number of treatments, in particular, secondary prevention of cardiovascular disease. The trial evidence consistently shows the benefits of aspirin, beta-blockers, ACE inhibitors and statins and all patients who are at risk should be assessed for suitability for these.

References available on request

C&D is accredited by the College of Pharmacy Practice as a provider of distance learning until March 2001.

Where is the evidence?

The following are examples of case histories where evidence-based medicine principles are used. These cases are designed to be used with the preceding article on evidence-based medicine. Compiled by Dr Rod Tucker

Case 1

A lady in her early 60s asks you about hormone replacement therapy (HRT). She had a heart attack three years ago and has read in a women's magazine that HRT can protect against heart disease.

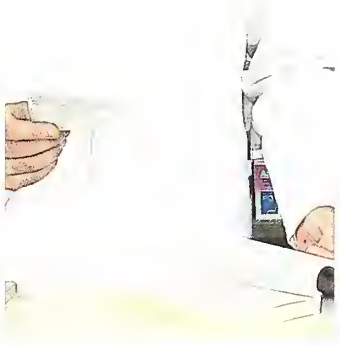
Her heart attack was very frightening and she wouldn't want to go through that again. She asks if it is worth going to see her doctor and getting him to give her HRT.

Before you can provide an answer, there are several important factors to consider as outlined below.

- Define the specific question you wont answering, eg "Is there good evidence that women ot a high risk of o second voscular event (such as another heort attock) con reduce their risk by toking HRT?"
- Where would you look for the answer – consider what access you have to drug information locolly.
- Once yau hove found the evidence, con you critically appraise, that is, ossess and interpret the evidence ond its relevance to the questian you have asked?
- Consider how you might relay the information back to the patient with due consideration for their feelings, as the potient in this cose appears to be already convinced that HRT is what she needs to toke and may simply be asking you to confirm her own beliefs.

The evidence for the cardio-protective effects of HRT has come only from cohort studies which are not randomised, though one meta-anolysis has suggested thot the relative risk of ischaemic heart disease in oestragen users is 0.56[9]. However, this anolysis can be criticised since it is not based on randomised studies and relates only ta the general question of whether or not HRT is cardio-protective. The information you need is evidence of the specific beneficial effects of HRT in women wha are at o high risk ot o further cardiovascular event. There hos only been one RCT conducted with such women and this found no difference in martality between HRT users ond ploceba[10].

There are on-going studies that will provide further answers ta the benefits of HRT and cardiavascular diseose, but at the present time it



appears there is na convincing evidence (at leost from RCTs) that HRT is beneficial in high risk patients. Thus, os an evidence-based strotegy, the use ot HRT in high risk patients cannot be recommended. There might be some cardio-protective effects ossocioted with HRT as has been suggested by the cohort studies ond you should endeavour to make this cleor to the patient. For a commentary on the effects of HRT, see the article by Barret-Conner[11].

Case 2

A man in his late 50s who is a regular customer of yours comes in one day to ask for your advice. His doctor has told him that he has osteoarthritis in his knees. The doctor has given him some paracetamol but he does not find that they are helping very much. He wants to know if there is anything stronger that you might recommend for him.

Again, yau will need to apply the same approach as described in the first case. You need to consider what options yau have far counter-prescribing for this patient. Possible options might include ca-codamal or ibuprofen and, os in the first case, yau need ta farmulate a specitic question. Far example, 'Is there gaad evidence that paracetamal and codeine in combination affer enhanced pain relief in OA compared ta paracetamal alane?' and 'Is there gaod evidence that NSAIDs are superiar ta simple analgesics far the relief of pain and symptams in patients with OA?'.

The evidence fram a systematic review[12] suggests that there is a slight but statistically significant increase in the relief af pain when 10-60mg af codeine is cambined with paracetamal. However, this review anly included ane study af patients with OA. The review alsa noted an increase in the incidence of opiote-reloted side-effects with the combinotion. Theretore, there is some, albeit weak, evidence ta suggest that there are benefits for OA treated with co-cadamal.

The secand question, regarding whether or not NSAIDs ore better than simple onalgesics has been addressed by an evidence-bosed guideline[13] which suggests that there is little difference between NSAIDs ond simple analgesics and most patients can obtain satisfoctory relief with poracetamol either olone or combined with codeine. The evidence-bose for this recommendation is again relatively weak, as there have been anly three gaod quality studies which have directly oddressed this particular question. Sa it would seem reasonoble to recommend that the patient takes co-codamal before considering ibuprofen.

Case 3

A middle-aged man comes in one day to ask for your advice about his aspirin tablets. He has angina and his doctor has told him that he should take aspirin every day to 'thin the blood'. Unfortunately, he is getting an upset stomach from taking his soluble aspirin 75mg tablets. His brother says there are some coated ones that you can buy which are much safer. He asks you whether or not these would be better for him.

Once again, yau shauld construct a specific questian. Far example, 'Is there evidence ta suggest that enteric caated aspirin 75mg is better talerated than the plain saluble 75mg tablets?'.

This specific questian has nat been addressed directly and mast evidence relates ta the incidence af gastro-intestinal bleeding and peptic ulcer farmatian. An averview at the gastro-intestinal (GI) taxicity af aspirin found a pooled odds ratia of 1.5-2.0 for GI bleeding[14] but this study does not specitically oddress the formulation of aspirin. Later cose-controlled studies have faund thot even doses as law as 75mg have an odds ratio tor peptic ulcer bleeding af 2.3[15] and that the relative risk for an upper GI bleed at doses of 325mg or less is 2.6, 2.7 and 3.1 for plain, enteric-cooted ond buffered aspirin respectively[16]. Finally, o review in the *Drug & Therapeutics Bulletin* in 1997 concluded thot there was no convincing evidence that at doses of 75mg, enteric cooted ospirin affered a significant advantage in terms of reducing major GI bleeds aver the plain, soluble form[17].

Unfortunately, all of these studies da not address the specific question as to whether or not the coated aspirin would be better talerated. As the local irritotion on the stomach is pH dependent it would seem reosonable that enteric cooted tablets would, at least in theory, praduce less dyspepsia but the same effect cauld be obtained by buffering the effects with food.

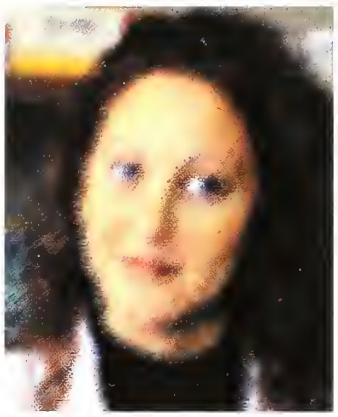
In summary then, there is little direct evidence avoilable to allow you to moke a specific recommendation, but it would be reasonoble to suggest that the patient tries the enteric caated ospirin to see whether ar not it makes a difference for them.

Conclusion

The above three cases show EBM can sometimes be incorporated into everyday practice but there is not always good evidence available to make an informed decision. In many cases, either clinical experience or professional judgement will still be needed. Most community pharmacists will be faced at some time or another by patients or other health professionals requesting advice or more information about an article that they might have read. It is important that pharmacists have the necessary skills to access the information or, if direct access is not possible, have an understanding of the medical literature and are able to critically appraise any information that comes their way. Such skills will become even more relevant with the increasing weight being attached to EBM – an inevitable event with the evolution of NICE. However, the problem for all healthcare professionals is that EBM is only a tool which cannot, and does not, provide an answer for each individual case.

Quality counts in life

Primary care pharmacist Mary Allen uses a case history to show how a few interventions can improve quality of life



David, in his late 60s, was terminally ill following cancer of the tongue and larynx, and was receiving palliative care. He had a tracheostomy and speaking tube. However, this was proving to be very frustrating; he was unable to use the speaking valve because as soon as he tried to speak, saliva poured from his mouth. His palliative care nurse and GP had already tried using hyoscine and antidepressants to dry up his secretions but none of these had worked. David had resigned himself to not being able to speak again.

Sue, his palliative care nurse, was determined to improve David's quality of life for what little time he had left. She knew that glycopyrrolate was used by subcutaneous injection to reduce secretions in palliative care and wondered if it was worth a try. David did not want the added encumbrance of a syringe driver. She read a report in a palliative care journal* about the use of an oral solution of glycopyrrolate for excessive drooling and took it along to show community pharmacist Jill.

What is glycopyrrolate?

Glycopyrrolate is a powerful antimuscarinic drug which does not cross the blood-brain barrier in significant amounts and so is less sedative than hyoscine and similar drugs. Similarly, it does not penetrate the aqueous humour of the eye so is less likely to cause blurred vision than hyoscine. It is already available in injectable form (as Robinul injection) and is frequently used to reduce secretions, particularly in the last stages of life.

The journal report suggested that a dose of 0.6-1mg orally, three times daily, could provide good control of drooling. Jill and Sue talked to the authors of the magazine article and then spoke to David's GP, pointing out that this was an unlicensed use but that other patients had benefited. He agreed to prescribe the solution subject to weekly review.

Jill supplied an unpreserved solution at a strength of 1mg in 10ml for easy titration of dose, in quantities of 250ml, with a seven day expiry and instructions to store in a refrigerator.

David started on a dose of 6ml (0.6mg) three times daily, by mouth, increasing to 10ml (1mg) three times daily. The higher doses provided better results. David was still drooling in his sleep so, after discussion, the night-time dose was increased to 20ml (2mg). David found this helpful and no adverse effects were reported. One day, due to a mix-up, he missed a couple of doses. The secretions increased as a result but subsided once normal dosing was resumed.

David remained on the solution for about six weeks until he died. The nursing team felt that use of this preparation medicine had certainly enhanced his quality of life. David found his voice again, even if just for a short time.

Would other patients benefit as David had done?

Following the success with David's treatment, the nursing team was keen to see if other patients with drooling problems would benefit. Jill subsequently supplied the solution on prescription for a number of patients with drooling caused by a range of disorders, including motor neurone disease and other neurological diseases as well as throat and oesophageal cancers.

The team found that responses were variable, and the solution worked best for those patients with PEG tubes. Some patients who were still able to swallow food by mouth found saliva was reduced to a level which made eating difficult.

As time went by, the team felt that most patients required 1mg three times daily, but that, other than David, no-one required more than this. Interestingly, there seemed to be a lag-phase of around a week or so before benefit was observed, so it may be that a loading dose might be useful. So far, they have been reluctant to explore this in case of adverse effects.

Considerations

Like other antimuscarinic drugs, glycopyrrolate can produce cardiac side effects including tachycardia, palpitations and arrhythmias, so the dosage used should be the lowest to control the drooling. Other side effects include constipation, and difficulty with micturition.

The short shelf-life of the solution imposed a high degree of organisation, and of co-operation, between the nurse, the patient's relative, GP and pharmacist.

Happy customer

The patient who has perhaps enjoyed the greatest (and longest-term) benefit has been Stan, a man in his 70s with oesophageal cancer. Stan's palliative care nurse and GP decided to try glycopyrrolate solution. Stan's drooling was so bad he felt unable to leave the house and sat at home all day with a handkerchief stuck in his mouth.

At first, his wife came to collect the weekly prescription. After a week, she felt there had been little change. The next week she reported that there was definitely some improvement. A week or two later she was thrilled to tell Jill that Stan and she had been out to a family party, so this was real progress.

Then, one day, Stan turned up to pick up his own prescription and has done so ever since. During a short spell in hospital, his glycopyrrolate solution was discontinued and the drooling started again. Things returned to normal on continuation of the solution.

A few months later, Jill was delighted to see that the front page of the local newspaper carried a story about Stan and his plan to take part in the annual charity walk in aid of the 'hospice at home' nursing team. Of course, he got lots of sponsors – and, yes, he walked all ten miles of the course.

**Palliative Medicine Vol 12 No 3 1998, p 207*

RESOURCES

Any pharmacists wanting further details of glycopyrrolate can contact the author at *maryallen@compuserve.com.*

Rennie® Duo - Product Information. Uses: Symptomatic treatment of complaints resulting from gastro-oesophageal reflux and hyperacidity. **Presentation, dosage and administration.** Oral suspension: Each 10ml (1 dose) of suspension contains: 1200mg calcium carbonate, 140mg magnesium carbonate and 300mg sodium alginate. Note. As well as the mechanical barrier to acid reflux provided by the alginate, the combination of two antacids provides a total neutralising capacity of 32mEq/H+. The usual dosage is 10ml to be taken after meals and before retiring. In cases of reflux an additional dose of 10ml may be taken between normal doses to a maximum total of eight unit doses in 24 hours. Recommended in adults only (above 12 years). **Side effects and precautions.** When used normally at the recommended dosage no undesirable side effects are expected. As with all antacid combination medicines caution should be exercised in patients with impaired renal function; prolonged use of high doses can result in hypermagnesaemia, hypercalcaemia or alkalosis especially in this group and plasma calcium and magnesium levels should be monitored. Prolonged use possibly enhances the risk of development of renal calculi. 10ml Rennie Duo contains 120mg sodium, which should be considered for patients on a restricted sodium diet. As with other antacids Rennie Duo can mask the symptoms of gastric malignancy. In patients also taking antibiotics it is advisable to recommend that Rennie Duo should be taken 1-2 hours after their other medicine. Rennie Duo, if taken as recommended is not hazardous to either foetus or infant during pregnancy or lactation. **Contra-indications.** Rennie Duo should not be used in patients having severe renal insufficiency, hypercalcaemia or hypophosphataemia nor in patients with nephrolithiasis or a known hypersensitivity to any ingredient. **Product licence number:** PL00031/0518. **Supply Classification:** GSL restricted to pharmacy only. Rennie is a registered Trade Mark. Packs and Prices: 50ml £0.84 (ex VAT), 180ml £2.88 (ex VAT), 500ml £4.37 (ex VAT). PL holder: Roche Consumer Health, 40 Broadwater Road, Welwyn Garden City, Herts., AL7 3AY. **Date of revision:** August 1999.

Roche

DOUBLE TROUBLE
*DUO*BLE SOLUTION

1 **£5 million national TV campaign**
-more and more customers will be asking for the trusted Rennie® brand name

2 **Major prescription business too**
Our representatives and medical promotion ensures more & more doctors are prescribing the 500ml pack

Rennie® *DUO*

Calcium carbonate, magnesium carbonate, sodium alginate

Rapidly relieves reflux and neutralises acid too

Anne Langan tells of her personal experience with the disease psoriatic arthropathy

Psoriatic arthropathy

Despite suffering from psoriasis since the age of seven, the devastating diagnosis of psoriatic arthropathy wasn't made until I was 32 and had suffered with it for ten years. Psoriatic arthropathy is linked to psoriasis, involving severe inflammation of the joints. Genetic in origin, the condition waxes and wanes and behaves in a similar way to rheumatoid arthritis, although the disfigurement is less apparent.

I am now a 37-year-old mother of two living in north London. I was born and raised in Ireland. As a child, I started to suffer with patches of dry skin on my knees, elbows and scalp. The condition didn't adversely affect me until, at the age of about 14, I started to suffer a series of severe ear infections (requiring surgery) and streptococcal throat infections. With each new infection, my psoriasis flared up until my tonsils were removed when I was 22. My psoriasis was very severe; my skin would weep, bleed, become infected and very itchy. I was nicknamed 'scab' at school and suffered bullying as a result.

At this time the doctors prescribed topical treatments, such as tar-based creams that had to be applied every night, followed by tar baths. It wasn't until my early 20s that I managed to get the psoriasis under control. I was referred by my GP to the Skin Diseases Hospital in Soho during 1986, where I was given UVB light treatment together with a range of topical creams over a period of nearly six months until the psoriasis was fairly clear.

In 1992 I became pregnant with my first child, Aisling. All through the pregnancy my skin was clear, but following the death of my father when I was seven months pregnant and the birth of Aisling, my skin became totally inflamed again.

I continued using topical and natural products to get some relief from the itching and dryness, but to no avail. In 1994 I became pregnant with my second child, Alex, and again the psoriasis cleared up. But within two weeks of his birth, it flared up again. At this time, I was getting severe pains in my joints – fingers, wrists, elbows, knees and feet. I had visited the GP a year earlier complaining of these pains. Blood tests were carried out and I was told there was nothing wrong. I saw doctors a further four times and they kept saying there was nothing wrong. I asked them for x-rays, because I felt that it must be psoriatic arthritis, simply because I suffered so badly with psoriasis. I was finally sent to see a rheumatologist who confirmed psoriatic arthritis immediately.

He strongly advised me to take anti-inflammatories, pain relief and methotrexate (a cytotoxic drug that is closely monitored) which would not only help the arthritis but also act as a disease modifying drug. I tried numerous varieties of anti-inflammatories including diclofenac. The diclofenac caused severe stomach disruption with bleeding diarrhoea and severe weight loss. I was then prescribed meloxicam, which I have tolerated well and it has given good pain relief.

I did not want to take the methotrexate long-term because of the risk of liver damage associated with this particular drug. After three to four months, I stopped taking it; the psoriasis was still severe at this stage, so my consultant persuaded me to go back on it and give it another try. I started back on the methotrexate about two and a half years ago and have never looked back. Within four months, the psoriasis is all but gone. I have a small occasional flare up on my face and patches on my legs, but I can live with this.

Life has involved some stressful upheavals over the past two years. I have lost four and a half stone in weight (which I am happy about), I am now divorced and have just started a new job. I am still taking the methotrexate and have to have liver function tests every six to eight weeks to monitor for side effects. I recently suffered some lower back pain, but now I revert to taking meloxicam to control the inflammation when I get a flare-up in pain.

I have always been quite an outgoing person, but because of the problems with my skin my confidence was completely shot to pieces. In the past two and a half years my confidence has come back and I am so much happier with my life.

RESOURCES

Psoriatic Arthropathy Alliance
PO Box 111, St Albans, Hertfordshire AL2 3JQ. Tel: 01923 672837. Helpline for sufferers and gives details of local contacts.

Psoriasis Association
7 Milton House, Milton St, Northampton NN2 7JG. Tel: 01604 711129. Help and information for sufferers, their carers and healthcare professionals on psoriasis and psoriatic arthropathy.

Use the phone to make it

As the role of the community pharmacist develops, pressure on resources becomes more acute. Extemporaneous dispensing is a vital service to offer, but raw material purchasing, stock control, health and safety assessments and dispensing documentation all demand that most vital resource - time.

BCM Specials offer a unique service enabling you to meet your patients needs for the time it takes to make a phone call. With our unrivalled range of formulae, a flexibility to meet your needs and a dedication to get the product to you as quickly as possible, BCM Specials can take the time out of extemporaneous dispensing.

BCM Specials putting your patient first.

www.bcm-specials.co.uk

Win a Sensational Shopping Spree worth £3,000 with Compeed

Compeed invites you to enter the Pharmacy of the Year Awards 2000, a scheme to find the best pharmacy in Britain, based on a series of business criteria

Launched for the first time in 1999, the Compeed Pharmacy of the Year Awards was won by Shorts Dispensing Chemist, Gosport, Hampshire, who won a trip to Copenhagen.

This year the Compeed Pharmacy of the Year Awards gives you the opportunity to:

- Demonstrate the high level of professionalism and service of your pharmacy
- Win a shopping spree worth £3,000 for your pharmacy
- Win one of 13 staff parties worth £200 each
- Win loads of Compeed goodies
- Capitalise on the increasing customer demand and interest in moist wound healing products like Compeed
- Utilise the FREE Compeed Point of Sale Kit provided by us, to create eye catching displays, attracting more customers
- Tell us what you think about the footcare sector, and let us know what else we can do for you.

The Compeed Product Range

The Awards Timetable

April 7 - Closing date for requesting entry pack

September 8 - Closing date for submitting your report

September 22 - Pharmacy of the Year Winners announced

How to enter

- Fax: 0171 839 1140
- E-mail: *sarah@cornucopia-group.com*
- Post: Compeed Pharmacy of the Year Awards, c/o Passion Communications, 27 John Adam Street, London WC2N 6HX.

When submitting your entry request, please ensure you include the following information:

- Your name
- Name and address of pharmacy
- Compeed products currently stocked
- State that you agree to stock Compeed Kidz during the Awards

The Entry Pack

Every entrant will receive:

1. A Free Compeed Goodie
2. A Pharmacy of the Year Report to fill in and return at the end of the Awards
3. Compeed Point of Sale Kit comprising:
   - Four Compeed Posters
   - One Compeed T-shirt
   - Two Compeed Baseball Caps
   - One Compeed Product Information Card
   - Five Compeed Customer Information Leaflets
   - Three Compeed Window Stickers
   - 1 metre of Compeed Decowell Card

Pharma Consumer Care pharmacy business managers (PBM)

There are 13 Pharma PBMs, who distribute Compeed for and on behalf of Coloplast Ltd.

Throughout the Awards your Pharma PBM will be available to offer you all the help and advice you need. To contact your local Pharma PBM simply call ***01202 314 824*** (Pharma Consumer Care is part of the Ceuta Group).

Compeed Point of Sale Kit

Pharmacy of the Year Judging Criteria

- Knowledge and understanding of the benefits of Compeed
- Merchandising of Compeed
- Compeed display
- New product listings
- Presentation of your Pharmacy of the Year report

Knowledge and Understanding of the Benefits of Compeed

You and your staff will be asked to complete a 'quick quiz' printed in your Pharmacy of the Year report about Compeed, which you can send into the entry address above.

Everyone who scores 8/10 or higher will receive a free Compeed goodie and points will be added to your overall score when we receive your final report.

Your Pharma PBM may also visit you and hold a quick 'on-the-spot' quiz.

If you know your facts your Pharma PBM will instantly present you with a free Compeed goodie.

Merchandising of Compeed

Merchandise the Compeed range as effectively as you can, preferably on a branded rotation stand, available from your Pharma Consumer Care pharmacy business manager.

Merchandising different products in different parts of the store is also effective as there is more chance of attracting the eye of a browsing customer.

Your Pharmacy of the Year report will ask you to describe how you have merchandised Compeed and ask your views on why this merchandising strategy has worked well for you.

Compeed Display

Using the Compeed Point of Sale Kit, create a window/in-store display. Use this opportunity to let your creative flair shine through. Take a photo of the display to include in your report.

New Product Listings

You will be required to stock Compeed Kidz at the beginning of the scheme and log any other new listings in your report.

Presentation of your Pharmacy of the Year Report

Fill in the Pharmacy of the Year report which is provided in your entry pack as fully as you can.

Inventive ideas and original presentation styles will be welcomed enthusiastically.

The report must be filled in and returned by Friday, September 8, 2000.

Only those who return the report will be eligible for consideration as the Pharmacy of the Year.

Prizes

First Prize

A shopping spree worth £3,000

Choose vouchers to spend on fashion, holidays, DIY, food and drink, music, videos, books and lots more.

13 Regional Finalists

Staff parties

One pharmacy from each of the 13 Pharma regions will win a staff party worth £200 and a specially commissioned wall clock for your pharmacy – to let the world know how good you are!

Quick Quiz Entrants

Compeed Goodies

Send your 'quick quiz' answers back to us and if you score 8/10 or higher, we'll send you a Compeed Goodie such as an umbrella, a box of chocolates, a T-shirt, or a toiletry bag*.

Every Entrant

Everyone who enters the Pharmacy of the Year Awards will receive a Compeed Goodie**.

So what are you waiting for? Enter TODAY!

Short's Dispensing Chemist, Window Display Winners of last year's Awards

Terms & Conditions: The competition is open to all independent pharmacies in the UK except employees of the promoters and their immediate families, the promoter's advertising agency and anyone else connected with creation and administration of the promotion. The closing date for entry pack requests is April 7, 2000. The closing dates for submitting completed reports is September 8, 2000. The 13 finalists and overall winner will be notified in writing by September 22, 2000. Details of the winners will be available after September 22, 2000, to anyone by sending an A4 SAE to Pharmacy of the Year, c/o Passion Communications, 27 John Adam Street, London, WC2N 6HX. For a full set of terms and conditions please write to the promoter, Coloplast Ltd, Peterborough Business Park, Peterborough, PE2 6FX.
* Subject to availability. ** Only one Compeed Goodie per participating pharmacy, subject to availability.

Community pharmacy makes the link with NHS Direct

Ash Pandya, pharmacy project manager NHS Direct – Essex, explains how the tie up with NHS Direct will soon be happening in other parts of England

Since March 1, pharmacists in Essex and Barking & Havering have been seeing patients who have formally been recommended to speak to their pharmacist after calling the NHS Direct pilot.

It is hoped that this pilot will lead to a national roll-out of the scheme. It went live after a thorough review of the existing computer algorithms used by NHS Direct nurses, rigorous consultations with local stakeholders and extensive briefings for both nurses and pharmacists.

The launch has brought together all three major pharmaceutical bodies, with extensive media coverage.

Why the link?

NHS Direct is proving to be very successful and judging by the numbers using the service, it is definitely here to stay. It is, therefore, important for pharmacists to work closely with NHS Direct as it will be a major player in the new NHS. The advantages of it to community pharmacy are:

- greater integration into the primary care network
- acknowledgement of professional clinical skills
- pre-qualified referrals
- greater footfall through pharmacies.

NHS Direct is still evolving and will continue to do so for some time yet. This may lead to further opportunities for pharmacy to work, either directly or indirectly, with the organisation.

The Fourth Disposition

What is the Fourth Disposition? It is, essentially, a recommendation from a nurse who has used a clinical decision support system (CDSS), that the most appropriate course of action to treat the symptoms presented is to visit a community pharmacy.

To allow for referrals to pharmacies, the existing CDSS algorithms had to be reviewed. A team at Keele University, led by Professor Alison Blenkinsopp, carried out the review. First they created a 'working definition of circumstances for a community pharmacy referral'. These circumstances were:

- if the appropriate treatment was a medicine that was only available from a pharmacy, or if significant additional advice would be available from a pharmacist
- if there was a low clinical risk associated with a pharmacy referral
- if the condition was one that is routinely dealt with by a pharmacist.

The team then looked at these circumstances within the existing end points (dispositions) to see which of these could be appropriate for a pharmacy referral. The existing end points, which they considered suitable for change, were ones that were either non-urgent GP referrals or homecare referrals where there would be considerable benefit from a pharmacist's advice.

Their findings identified 182 opportunities for a pharmacy referral, affecting 68 guidelines. These recommendations have now been integrated into the current CDSS.

When a caller contacts NHS Direct Essex with a symptom, a nurse will go through the CDSS and this may end with the caller being referred to a community pharmacist. The caller will be given a reference number to show at the pharmacy, which identifies them as an NHS Direct referral.

The pharmacist will then be able to consult with the patient using their normal routine and to provide the appropriate advice or treatment. This will not change the way pharmacists operate, but it will help to enhance the public's image of community pharmacists as professionals.

A joint partnership

One of the key aspects of this pilot has been to brief both sets of professionals involved about their roles within the partnership. Joint briefing sessions were delivered by the Centre for Pharmacy Postgraduate Education. In true CPPE tradition this involved both pre- and post-workshop tasks and an evening workshop attended by both pharmacists and nurses. These were briefing sessions and not training sessions. They were designed to instil confidence in each other's profession, and also to give all participants an outline of how the pilot would function and what their role in it would be.

Early figures indicate that up to 60 per cent of pharmacies in the region were represented at the briefing sessions. This excellent response is a tribute to the tremendous amount of hard work done by the LPCs in encouraging contractors to attend.

The initial feedback from these sessions shows a 'satisfaction rate' in excess of 90 per cent. One of the reasons for this success was that both professions could see how the other handled queries. This was found, in general, to be in the same manner.

Ash Pandya

Conditions that may now be referred to Pharmacy:

Adult	*Paediatric*
Abdominal pain	Cough
Cold symptoms	Insect bites
Cold sores	Mouth ulcers
Hay fever	Lice
Rash	Rash

The Evaluation

Like most areas of NHS Direct, this pilot will be thoroughly evaluated. Sheffield University, which is responsible for evaluating the entire NHS Direct project, will carry out the work. It will aim to look at:

- who, when, and where patients present themselves
- the presenting conditions
- patient satisfaction with the service
- impact on workload of pharmacists
- impact on workload of other immediate healthcare services
- whether the prescription status of a patient impacts on the willingness of a patient to self-care with a recommended product.

This independent evaluation will provide a lot of raw data that may help to show the impact that pharmacy can have in dealing with minor ailments within primary care. One of the most important aspects of the evaluation will be to assess the impact of 'pharmacy recommendations' on other immediate healthcare services, for example, GPs.

The evaluation will include patient surveys, both pre and post going live. Following consultation with an NHS Direct referred patient, community pharmacists will also be asked to complete a simple evaluation form. This will identify the symptom(s) presented, the pharmacist's recommendation, the patient's action and prescription status.

It is anticipated that the results of the evaluation will be available by the end of the year.

Looking at the conditions that may now be referred to pharmacy, it can be seen that this pilot will not really change the way pharmacists consult with their patients. What the pilot will achieve is increased public (and Departmental) awareness of the clinical skills possessed by pharmacists in dealing with minor ailments.

where is the
largest community
pharmacy show
in the UK

SkyePharma in Bioglan deal

SkyePharma has signed an agreement with Bioglan Pharma to manufacture, market and distribute Solarase in Europe. The product is a topical gel for actinic keratosis, a precancerous skin condition caused by over exposure to the sun, and has received marketing approval in the UK and four other European countries.

Strong sales in February

Pharmacists were among the best performing retailers in February, according to the Confederation of British Industry's distributive trades survey. Seventy-one per cent of pharmacy respondents reported higher sales – compared with only 27 per cent during the same period last year. However, overall retail prices fell for the first time in the survey's record.

Qualified Person courses

RSSL-Pharma, based in Reading, is introducing new courses to its training portfolio to help those who want to gain Qualified Person (QP) certification. The QP training schedule consists of 14 courses that range from pharmaceutical law and administration to investigation of medicinal products. For more information contact RSSL-Pharma on: 0118 986 8541.

Capital idea

London-based Capital Exchange has launched an on-line information service for companies who are looking for finance and potential investors. The site – *www.capitalexchange.co.uk* – is aimed at entrepreneurs who have traditionally faced problems raising between £25,000 and £1.25 million. Its contents include a guide to everything an owner/manager needs to know to raise money, as well as access to business plans from companies in 34 different industry sectors.

MCA to clampdown on PI cold storage facilities

The Medicines Inspectorate has warned it will be tightening up on parallel importers who bring products into the UK that require cold storage.

Dr Gordon Munro, head of the Medicines Control Agency's inspection and enforcement division, said on Monday that all licence applications for PIs which require cold storage were referred and action would be taken if facilities were not available.

"We are looking at cold chain shipping. There are people who do not comply with that at present," he said.

"It is our intention that regulatory activities will be conducted without prejudice or favour. That will apply to short-liners too," he told guests at the British Association of Pharmaceutical Wholesalers' dinner in London.

He endorsed the temperature control protocol drawn up by the BAPW, and said he hoped it would "go forward into Europe".

BAPW chairman Sandy Young said that while the standard was used by manufacturers and BAPW members, it had not been adopted by short-line or Continental wholesalers. Fridge lines are increasingly being imported as PIs by traders who do not conform to the protocol.

"I cannot understand why a pharmacist would contemplate buying such products from a short-liner where the storage and transportation standards are suspect," he said.

Mr Young also accused short-liners of contributing to the shortage of generic drugs. The "real culprits", he said were "short-line wholesalers, perhaps aided and abetted by generic manufacturers and the lack of direction from the Department of Health, which closed its ears to the consequences of introducing patient packs".

The market would never return to the pre-1999 situation as too much has changed, he said. "It costs as much for a wholesaler to hold and distribute a cheap generic as it does an expensive ethical and so they are less profitable.

"Pharmacists are also buying less product more frequently, thus increasing the costs of distribution. Despite the high volumes of generic sales, many products have fallen into the 80 per cent of a full-line wholesaler's inventory where profits are not made. Full-liners may well find it necessary to insist on minimum order levels in order to cut costs," said Mr Young.

He had little hope that the government sponsored investigation into the market would find a "realistic and practical solution", because at the moment "it appears to be looking for a scapegoat".

● The decision by the National Institute for Clinical Excellence to ban the flu drug Relenza on the NHS was "a disaster for the pharmaceutical industry in the UK", according to Dr Trevor Jones, director-general of the Association of the British Pharmaceutical Industry. However, he said the ABPI had now developed a positive relationship with NICE. "The problem is how much NICE will be controlled by the government machine, and how much it will be truly independent."

Chancellor may revise taper relief

Gordon Brown, chancellor of the Exchequer, could improve taper relief at next week's budget, according to Gerry Jackson, a tax specialist with the UK 200 Group.

Taper relief replaced retirement relief, which offered an exemption on capital gains tax (CGT) for those selling their businesses. Under the new system, the rate of CGT on business assets would taper over five years, rather than the present ten, and taper relief is increasing to compensate for the end of retirement relief.

However, people selling small- or medium-sized businesses do not think taper relief is as beneficial as retirement relief. The chancellor is aware of this and has said he will change the new system, but he has not yet said how.

One option is to reduce the threshold for taper relief: it is currently available to those who own at least 25 per cent of a company, or 5 per cent if they are also full-time employees of that company.

Anyone looking to sell their businesses now might want to wait until after the Budget. "But we can never be sure that there won't be a sting in the tail of the new scheme," said Mr Jackson.

The chancellor will be under some pressure not to squeeze too many wallets, considering the Government could call an election some time next year.

He is therefore expected to lift the inheritance tax threshold from £231,000 to at least £250,000, and may change other allowances, too.

Some tax cuts could also be announced.

The chancellor could abolish, or reduce, the 0.5 per cent stamp duty on UK equities. This would raise more than £3 million and, if left untouched, could force some investors to buy shares from Continental Europe (the duty does not apply to foreign shares).

Meanwhile, the Government's Better Regulation Task Force, has called for an alignment of the income tax and national insurance contribution systems, and a look at the pay-as-you-earn structure to make it easier for small businesses to collect taxes.

The chancellor may also help these firms by making it easier for them to obtain capital allowances to buy computers.

Mr Jackson warned that the chancellor could increase stamp duty on residential houses to dampen the overheating market, and may also increase National Insurance.

"The 2000 Budget will be preparing the ground for the next election and so it will be doing its best to appear more generous than it is. Do not expect too much, and you should not be disappointed," he said.

● UniChem Commercial Support will be sending its customers a booklet explaining how the Budget will affect them. It was compiled with the help of the UK 200 Group. Pharmacists who are not UniChem customers can buy a copy for £5 by calling: 020 8391 7110.

For advice from the UK 200 Group call: 0800 919243.

AAH Pharmaceuticals has appointed Ian Bray as marketing director. Mr Bray was previously head of marketing at Shropshire-based Müller Dairy, whose brands include Müller Yoghurts and Müllerice. Steve Dunn, AAH's managing director, said Mr Bray's experience of fast moving consumer goods "means he brings skills and ideas which will complement and expand upon those of the rest of the team".
The wholesaler has also promoted David Downs to branch manager of its Belfast depot – he was previously assistant branch manager. Violet Johnston, formerly stock control supervisor, has been appointed assistant branch manager. The depot is having a £1 million refit

welcome to

the **future** of pharmacy

chemex 2000

3/4 september / olympia 2 / london

Welcome to the **largest annual gathering** of community pharmacists and manufacturers in the U.K. We pride ourselves at Chemex by offering to exhibitors an unrivalled number of healthcare professionals that no other event can match. Whilst all exhibitions make claims about being the **"biggest" and the "best"**, Chemex can verify this as it is the only show in its market that can prove its 2,900 attendance figure with an independent ABC audit, other shows remain cautious about verifying their visitor numbers.

Telephone 01732 377256

Fax 01732 377179

THE CHOICE IS SIMPLE - COME TO THE BIGGEST AND BEST

SPONSORED BY CHEMIST & DRUGGIST

SUPPORTED BY NPA

- Over 160 participating companies many of which do not exhibit at other shows
- A visitor audience of nearly 3,000 healthcare professionals under one roof
- The full backing of the Miller Freeman Pharmacy Group including Chemist & Druggist
- Advice from professional bodies including NPA, PSNC, CPAG CPP & PAGB

COMING EVENTS

MARCH 20

NICPPET at The Everglade Hotel, Londonderry, 7.30 for 8pm. 'Reporting adverse drug reactions'.

MARCH 21

East Metropolitan Branch, RPSGB, at the Wanstead Library, Spratt Hall Road, Wanstead, E11, 7.30 for 8pm.

NICPPET at Malone House, Barnett's Park, Upper Malone, Belfast, 7.30 for 8pm.

Bradford Branch, RPSGB and the University Pharmacy Practice Department Lecture series in Room D4 at the University, 7.30pm. 'A journey through your alimentary canal'.

MARCH 22

Bristol Branch, RPSGB, at the BAWA Leisure Centre, Filton, 8pm. 'Palliative care update'.

MARCH 23

Bedfordshire Branch, RPSGB, at the conference Centre, Silsoe College, Silsoe, 7.30 for 8pm. 'Getting high on plants'.

Slough & District Branch, RPSGB, at the John Lister Postgraduate Centre, Wexham Park Hospital, Slough, 7.15 for 8pm.

Somerset Branch, RPSGB, at the Manor Hotel, Yeovil.

Parallel importers win repackaging court case

Four major pharmaceutical manufacturers have lost a High Court bid to prevent parallel importers from repackaging parallel imported pharmaceuticals.

Glaxo Wellcome, Boehringer Ingelheim, SmithKline Beecham and Eli Lilly had sued Dowelhurst and Swingward for allegedly breaching their trademark rights.

Dowelhurst, for example, parallel imports GW's Serevent, which it reboxes in pale blue livery that carries a large 'C' and the brand's generic name: salmeterol (C stands for Concept Generics).

Earlier rulings by the European Court of Justice (ECJ) had suggested that parallel imports could be reboxed only if it was "necessary", according to the manufacturers. The repackaging undertaken by Dowelhurst and Swingward, they argued, was not necessary.

Parallel importers claim they rebox products if the trade name abroad is different to the one in the UK, and if the pack size is different. They then have three options: make a copy of the originator's pack, introduce their own design or livery, or re-name the pack as part of an own-label range.

John Barker, chairman of the British Association of European Pharmaceutical Distributors, which represents most parallel importers in the UK, said its members have largely reboxed to ensure the pack details are in English.

"We've wanted to enhance patient compliance instead of confusing them," he said.

The parallel importers said many pharmacists approved of repackaging. They sent out questionnaires to around 4,000 pharmacists, 1,200 of which replied. Practically all the pharmacists said they preferred their parallel imports to be reboxed, 65 per cent said they would sell more PIs if all of them were reboxed (35 per cent said this would not make a difference to their PI sales).

Mr Justice Laddie, the presiding judge, said the Medicines Control Agency acted as a buffer for potentially dangerous repackaging because it reviewed importers' product information leaflets and boxes before it granted them product licences for their imports. "So it's unlikely that the product would be allowed in the UK if there was a significant risk to its quality," he said.

The evidence he had seen failed to show that the importers' repackaging "...either caused, or was likely to cause, any damage to the specific subject matter of the claimants' trade marks".

Restricting this repackaging would therefore be a "disguised restriction on trade" and was contrary to the Treaty of Rome.

However, parallel importers must give the relevant manufacturers two days' notice about repackaged products they intend to introduce into the UK.

Mr Barker said he welcomed the decision "...which is clearly a common-sense one and is in the interests of the patient".

SmithKline Beecham said it would seek leave to appeal before the ECJ. The other manufacturers were unavailable for comment as *C&D* went to press.

Reckitt Benckiser profits fall to £290m

In its first results since its merger, Reckitt Benckiser's year-end pre-tax profits fell 20 per cent to £288.7 million – a little below analysts' expectations.

If you include merger costs, which amounted to £220m last year, transaction costs and non-operating items, the group traded at a loss of £36.5m.

Its sales rose 1 per cent to £3.054 billion. RB's health and personal care division benefited from strong OTC sales and grew 3 per cent to £391.5m. The group said the flu crisis boosted its OTC sales in the UK late last year. Lemsip Max Strength performed particularly well.

Bart Becht, RB's chief executive, said the merger reorganisation would yield annual savings of £160m by the end of 2001. The group's performance would be better this year due to "...a new strategic focus, more innovations, many regional roll-out opportunities and significant funds to invest behind them".

He said he believes RB could increase its profits after tax by 25 per cent this year, partly because the merger changes will lift its profits by £38m.

Asian pharmacist tycoons prosper

Asian pharmacists running pharmaceutical companies nearly doubled their combined wealth to £448 million last year.

Heading the rank is Vijay Patel and his architect-trained brother Bikhu, who own Waymade Healthcare and the Chemys pharmacy chain. Both companies and other assets are worth an estimated total of £203 million, up from £113 million last year, and this places the brothers seventh in a list of Britain's 200 richest Asians.

Further down the list is Ketan Mehta, who founded pharmaceutical wholesaler Necessity Supplies, which would be worth around £60 million if it was quoted on the stock market, according to the list's publisher *Eastern Eye*. The company's valuation is up 172 per cent on last year, which places it 24th on the list.

Meanwhile Ajit Patel, who set up Goldshield Healthcare, more than doubled his wealth to £32 million and is number 48 on the list.

He is closely followed by Bharat Shah and his family who own pharmaceutical wholesaler Sigma Pharmaceuticals. At number 53, they are worth £30m.

Don't get left behind!

Make sure your company is ahead of the competition. Promote your products & services in

Chemist & Druggist Directory

- the only directory to cover ***all*** aspects of your industry from manufacturers to wholesalers, retailers to the NHS.

To find out more about how you can reach out to 9,000 Pharmaceutical industry professionals, call us now on

Tel: 01732 377591 or Fax: 01732 367301

to register for a media pack.

Miller Freeman
A United News & Media company

Miller Freeman
INFORMATION SERVICES

Classified

Appointments £27.00 P.S.C.C. + VAT minimum 3x1. Generol classified £18.00 P.S.C.C. + VAT minimum 3x2. Box numbers £15.00 extro. Avoiloble on request. Copy dote 12 noon Tuesdoy prior to Soturdoy publicotion. Concellotion deodline 10om Fridoy; one week prior to insertion dote. All concellotions must be in writing. Contoct Debro Thockeroy. Chemist & Druggist (Clossified), Miller Freemon UK Ltd, Sovereign Way, Tonbridge, Kent TN9 1RW. Telephone 01732 377493, Fox: 01732 377179. Internet: http://www.dotpharmacy.co.uk.

All major credit cards accepted

VISA DELTA Access SWITCH

APPOINTMENTS

APS BERK

PRODUCT MANAGER

COMPETITIVE SALARY

CAR

EXCELLENT BENEFITS

If you have the appropriate background and experience, please apply in writing, including a CV and details of your current salary, to:

Human Resources
APS/Berk
18 Bruntcliffe Way
Morley
LEEDS SL27 0JG

As part of a multi-national generics company, APS Berk is one of the country's leading suppliers of quality generic pharmaceuticals. An opportunity has now arisen for a Product Manager to join our Sales & Marketing team in Yorkshire.

Reporting to the Group Product Manager, responsibilities will include:

- Achievement of future growth targets (in sales, volume and profit) for an extensive product range, through tactical planning and creative ideas
- Working closely with key departments on managing the supply chain
- Supporting the sales and marketing management team in achieving the business targets

Ideally, you should be of graduate calibre and have experience in managing a product portfolio or marketing - in either a pharmaceutical or FMCG environment. You should possess business acumen and analytical insight, as well as creative flair and vision to assist in driving the business forward. Strong interpersonal and communication skills are essential to work effectively at all levels in the organisation.

TEVA®

APS Berk is a member of the TEVA International Group of Companies

FOUR LANE ENDS
Tyne & Wear

Full time Pharmacist Manager required due to retirement. Established community pharmacy which is part of an expanding independent group. Commitment to modern aspects of retail pharmacy essential. We are prepared to wait for the right applicant and will consider newly qualified. Salary £25k to £30k.

Interested? - **Telephone: Lucy Haig on 0191 285 3191 or Fax on 0191 285 9391 or e-mail on ChrisHF@aol.com**

DISPENSING/ COUNTER ASSISTANT

Experienced person required for West Dulwich pharmacy SE21. Full or part-time. Salary according to experience. Please phone Mary Williams on 0181 670 2119

NORTHERN IRELAND

Pharmacist Manager required for North West area. Monday to Friday, 9am to 5.30pm. Closed 1 hour for lunch. No rota.

★ Newly qualified welcome
★ Good supporting staff
★ Minimum paperwork ★ Excellent salary

Please contact:
Anthony Toner, Heron Chemists
Tel: 028 796 28203

DONEGAL
PHARMACIST MANAGER

Required

- For recently refurbished shop
- Part of a small friendly group
- Excellent wages and conditions
- Accommodation available if required

Apply to PO Box 3568
Chemist and Druggist Classified
Miller Freeman, Sovereign Way, Tonbridge, Kent TN9 1RW

Dispensing/Counter Assistant

Required for a busy pharmacy in London SW11/SW12

Full or part-time considered

Salary negotiable and dependent on experience

Please contact Mr S. Amin
0171 223 6334 and 0181 673 1738

DISPENSING/ COUNTER ASSISTANT

For a modern pharmacy in St John's Wood NW8.

Do you have:

- Good customer service skills
- The ability to organise yourself

We are looking for a capable member of staff to join our small friendly team. Full time or part time considered with a salary package to match your abilities and experience.

Please contact Dilip on
020 7254 2696

LOCUMS

ESSENTIAL LOCUM SERVICES ELS

Pharmacists, locums and Technicians are invited to register.

• Nationwide coverage •
• Competitive prices •

Call Sue on: 0121 444 0075

BUSINESS WANTED

DAY LEWIS

CHEMIST *We Care*

DAY LEWIS

Progressive chain of 60 shops seeks to acquire Pharmacies with turnover of in excess of £400,000 in Southeast England and East Anglia. Freehold purchases. Matter treated in the strictest confidence. For a quick decision contact:

Day Lewis Group, Bensham House,
324 Bensham Lane, Thornton Heath, Surrey CR7 7EQ
Tel: 0208 689 2255 ext. 221. Mobile 0860 484999. Fax: 0208 689 0076
Email: DayLewis@aol.com

APPOINTMENTS

Technical Editor

Chemist & Druggist

Do you think you could co-ordinate a leading journal-based distance learning programme for community pharmacists? *Chemist & Druggist*, the weekly title for community pharmacists, is looking for someone who can.

C&D requires a Technical Editor to be responsible for its twice-monthly Pharmacy Update, an accredited continuing education programme. You will also be able to apply your writing skills to keep pharmacists up to date about new drugs and clinical developments.

We're looking for someone with good writing skills as well as commissioning and sub-editing experience. A pharmacy qualification is desirable, as is knowledge of community pharmacy practice and the NHS.

This full-time position is based in Tonbridge, Kent. For the right person, it offers a competitive salary as well as all the benefits you would expect from a major employer. To find out more, or to request an application form, please contact Patrick Grice on 01732 377296.

Email: pgrice@unmf.com

Miller Freeman is an equal-opportunity employer.

un Miller Freeman
A United News & Media company

Pharmacy 2

UK's FIRST ON-LINE PHARMACY

PHARMACY DISPENSERS/ASSISTANTS

Are you self-motivated and interested in joining the UK's first on-line Pharmacy? Excellent salary, bonuses, training and promotional prospects.

Pharmacy 2U is looking for dispensers/assistants to assist our Pharmacists in dealing with customers and preparing orders for distribution.

The successful applicants must have a Pharmacy background, NPA or equivalent qualifications and computer skills would be an advantage but not essential.

If you are interested in joining our rapidly expanding team apply in writing with full CV to the

Personnel Manager,
Pharmacy 2U Ltd, Unit 4, Shaftsbury Parade,
Hare Hills Lane, Leeds LS9 6PJ

or e-mail in Microsoft Word format:
personnelmanager@pharmacy2u.co.uk.

Closing date for applications 29th March.

EQUIPMENT FOR SALE

FOR SALE FUJI MINILAB

Film Processor FA Compact FP230B
Paper Printer Compact II PP541B
Complete with all accessories and lenses.
Will Print 6x4, 5x7 and 8x6
Will Process 135, 126 and 110 Films
In Very Good Working Condition
Ring: 0181 311 0898

PRODUCTS AND SERVICES

NEW  CITRUS MAGIC®

100% NATURAL AIR FRESHENERS
FIVE FRAGRANCES: TROPICAL BLEND, ORANGE, LEMON, LIME AND MANDARIN
STARTER PACK: 24 PIECES 3.5 OUNCE DISPENSERS WITH COUNTER DISPLAY UNIT, TESTER, INFORMATION LEAFLETS.
PACK PRICE: £42.96 + VAT (UNIT PRICE £1.79 + VAT) RRP: £2.99
INFORMATION AND ORDERING FROM: CITRUS MAGIC®
151 AIRPORT HOUSE, PURLEY WAY, CROYDON CR0 0XZ
PHONE: 0181 781 1900 FAX: 0181 681 5557
FREEPHONE: 0800 074 2768

Man Med

MANUFACTURERS OF SPECIAL PHARMACEUTICAL PRODUCTS
Bespoked Tailors of Pharmaceuticals offering
A TRADITIONAL SPECIALS SERVICE
for that "specials" patient cared for by that special professional
Where confidence in quality and price is a must and where the minimum order value is ONE
Contact Karol Pazik, Director, on 01296 394142.
Mandeville Medicines, The Specialists in Specials.
For sterile, non-sterile and assembled specials, clinical trials supplies and a free help line.

White & Luckman
Stocktakers, and Business Agents
Tel: 0121 708 1530 Fax: 0121 708 1560 Mobile: 07801 847359

PHARMACY FOR SALE
East Birmingham

Retirement sale of local community Pharmacy
1999 turnover £556,000 GP 21.43%
NHS items average 3400 per month, counter takings £2,500 per week
offers in the region of £250,000 for goodwill/fixtures plus S.A.V.

41, Warwick Road, Olton, Solihull, West Midlands B92 7HS

BUSINESS FOR SALE

Pharmacy Sale
(Retirement)
London SW11.
Lock-up pharmacy, annual turnover **£531,000.** NHS items PM 3143 in 1999
Estimated turnover **£560,000.**
New Lease Rent **£12,500 PA.**
Offer invited **£300,000** plus SAV
Please contact 0171 2281821

EQUIPMENT FOR SALE

COMPLETE MINI LAB FOR SALE

Under 2 years old.
Noritsu 2301 printer/processor
35mm and APS format,
3 paper magazines.

Noritsu 450-L film processor

All of the above plus complete accessories package

£48,000 + VAT

Call Ian on:
0141 333 9444

EPoS Solutions

The next generation of retail scanning EPOS technology

Prices Start From
£1,999 + VAT

Free Call
0800 056 5561

TO ADVERTISE IN THIS SECTION
Contact
DEBRA THACKERAY
on
01732 377493

PRODUCTS AND SERVICES

www.3pears.com

Three Pears Wholesale Ltd

Specialists In

Toiletries
Aftershaves
Perfumes
Pharmaceuticals
Fancy Goods
Household Items
Pound Retail Lines

ONLINE ORDERING
DELIVERY SERVICE
SPECIAL OFFERS
UPDATED DAILY

www.3pears.com

TEL: 0121 559 5351
FAX: 0121 559 5353

SHOP FITTING

RAPEED DESIGN

The future in retailing

- Providing a new dimension in Pharmacy design and Pharmacy refurbishment
- Helping in creating a professional environment for your customers, staff and yourself
- For a fresh new approach to pharmacy refitting ring us on 0181 778 5070

Finance Service Available

Fax: 0181 776 7912 ● E-mail: info@rapeed.co.uk
5 Newlands Park Sydenham London SE26 5PE

SHOP FITTINGS WANTED

WANTED

Old Chemist Drawers (Drug Runs)

Cash paid. Will collect

Telephone: 01327 349249

STOCK MARKET

The stock marketT

ZIRTEK 7's exp Jun 00

ONLY 75p each

(min purchase 20 packs)

Tel: 0845 458 4040 Fax: 0845 458 4041

E: stock-market@chemist.com

www.the-stock-market.co.uk

Business link

A free service for C&D subscribers

Free entries in 'Business Link' (maximum 30 words) are restricted to community pharmacist subscribers to *Chemist & Druggist*. No trade advertisements will be permitted. Adverts must be submitted on the coupon (right), which must be properly completed, and include an expiry date for products. Acceptance is at the discretion of the Publishers and depends on the space available. Pharmacists should only advertise medicines for sale where the product is discontinued or in short supply. Medicines must be unopened and in original packaging.

To: Business Link, CHEMIST & DRUGGIST, Miller Freeman House, Sovereign Way, Tonbridge, Kent TN9 1RW.

PLEASE COMPLETE IN BLOCK CAPITALS

Surname .....

First names .....

Address .....

..... Postcode .....

Personal RPSGB Registration number .....

Telephone Number .....

Proposed advertisement copy (maximum 30 words)

.....

.....

.....

.....

Back issues

Boot courts controversy

Jesse Boot was courting controversy this month a 100 years ago with an advertisement placed in *C&D* for his cash chemists.

Mr Boot claimed that, at his chemists: "Every branch is under the management of a chemist qualified by examination of the Pharmaceutical Society." At many private shops, Mr Boot claimed, there was no such chemist in charge. He quoted a *Pharmaceutical Journal* article to back up his claims.

A riposte from the *PJ* claimed that Mr Boot's mis-quotation was "perilously close to lying". And it went on to attack him for his "malicious intention" and "puerile manifestation of petty spite". **Xrayser** lambasted the *Journal* for its ambiguous claims.

Graham Hill invites readers to take up the 'Gillette Challenge' in 1975 and improve their sexiness rating with a new MGB GT

Representing both sides of the story, *C&D* published a letter from Mr Boot claiming that: "No greater danger to the public can be imagined than for a private chemist to have two shops under his own name over which he diffuses his own qualification … where the shop boy can be trotted across to the principal when any scheduled poison is wanted, or else the unqualified assistant supplies it *sub rosa*." Sounds like a forerunner to the supervision debate.

Mr Boot claimed: "There is too much winking at the shortcomings of private chemists on the part of the Pharmaceutical Society." Those were the days when people were not afraid to speak their minds and healthy debate took place in the public arena.

In 1950, *C&D* claimed to be the magazine that "circulates through the pharmaceutical, chemical, drug, essential oil, perfumery, cosmetic, toilet preparation and allied trades throughout the world". It was the "official organ of the Pharmaceutical Societies of Ireland and Northern Ireland, the Chemists' and Druggists' Society of Ireland, and of other chemists' societies in the Empire".

The March issue's editorial comment criticised the opinion of the health minister, Aneurin Bevan, that "some economies ought to be made as soon as possible" to slow the rising cost of the NHS. Mr Bevan thought cuts could be made in the cost of proprietary medicines, which have become "a part of the racket in civilised society", and also in the bulk purchase of medical supplies.

The editorial concluded: "The crux of the question is whether the expense of the researches which result in the best proprietaries is to be allowed to the manufacturers in the prices paid to them. In carrying out unconsidered cuts in that direction, the chancellor might be cutting progress in cutting costs."

Even in 1975, *Which?* magazine was out to get pharmacists. It claimed that "about one pharmacy in five that we visited … about a potentially serious illness failed to give any advice, or sold … inappropriate medicine". The Society responded by calling the report "fair, mildly critical, but mainly complimentary…"

Right: Half a million signatures collected by National Pharmaceutical Union members were delivered to the House of Commons in March 1975 by (l-r) Michael Shersby (MP for Uxbridge, whose wife was a pharmacist), Mr J Goulding, NPU press officer, David Sharpe, NPU executive committee vice-chairman, Mr J Wright, director of the NPU group, and Tim Astill, deputy secretary, NPU. Petitions requested that MPs oppose the imposition of more rates of VAT on pharmacists

APPOINTMENTS

The new general manager of the L'Oréal Paris division in the UK is Sophie Gasperment. Mrs Gasperment was previously worldwide director of cosmetics development for the L'Oréal Group in Paris. She takes over from Christophe Leguay, who is returning to Paris to take up new international responsibilities.

Sophie Gasperment

Pharmacist enters the fast lane

A Devon pharmacist is a championship favourite in this year's Super Coupe Cup motor racing competition.

Paul Dishman, proprietor of St Thomas and Exwick pharmacies in Exeter, has just completed pre-season testing in his re-built Volkswagen G40. He is hoping that his car, which is faster than a Porsche 924, can help him improve on last year's fourth place.

The car is the same as last year but it has been re-built by Aardvark Motorsport in Leicestershire. Slick tyres give it an added advantage over rivals. In six years of motor racing, Paul's previous bests have been 'best of class' in 1997 and 'outright winner' the following year.

To be in with a chance this year, Paul will have to do well in 12 races around the country between now and October. His first race of the season is this weekend at Brands Hatch.

Paul Dishman with his Volkswagen G40

Winners of *C&D*'s marathon draw

Carwyn Jones and Andrew Munro are the lucky winners of the *C&D* prize draw for London Marathon places in conjunction with Johnson & Johnson, MSD.

Luckily the two pharmacists are experienced runners so they should be able to get the necessary training in before the big day on April 16.

Carwen, from the Tesco In-store Pharmacy in Bangor, was already in training – he had applied for a place but had been rejected. He ran in last year's New York Marathon and expects to complete the distance in about four hours. He is raising money for MacMillan Cancer Relief.

This will be Andrew's first marathon, but even so he is confident that he can achieve a time of three hours. The man from Boots in Forres, Morayshire, ran a half marathon just last weekend. He is raising money for Noah's Ark, a local playgroup for children with special needs.

Good luck to them both!

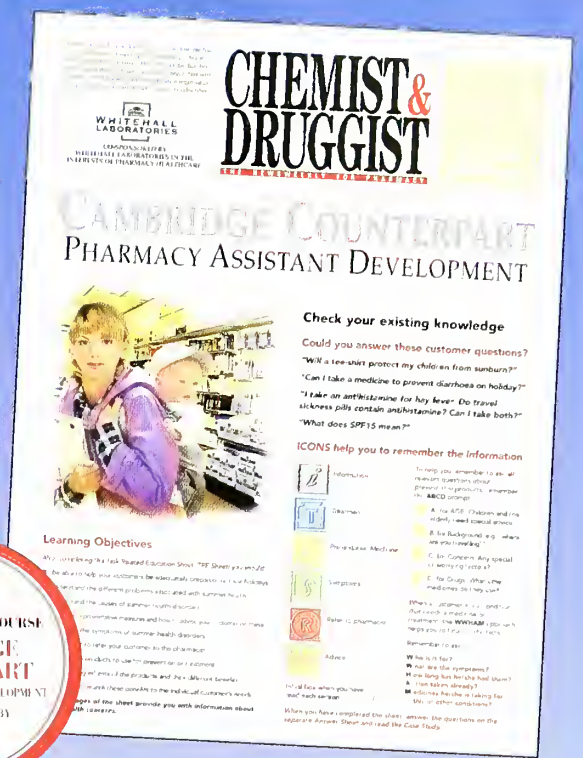
The easy way

CHEMIST & DRUGGIST

o train your medicine sales assistants

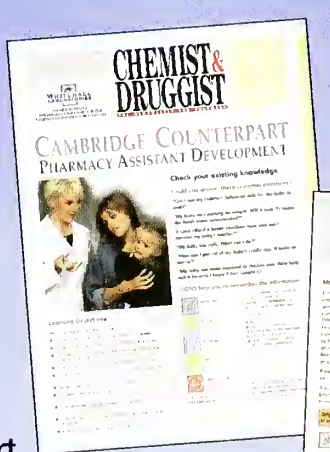
CAMBRIDGE COUNTERPART

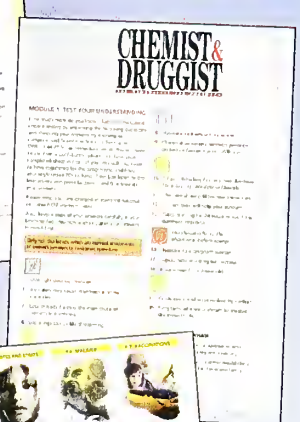
Why pay more?

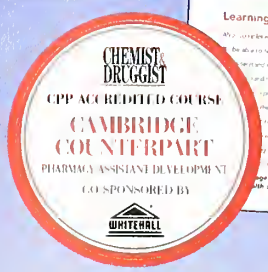


ambridge Counterpart is:

- exible
- ffordable
- asy to join
- asy to use







u could pay more
an double for other
urses
d remember,
mbridge Counterpart
ers
tant results on the phone

assistants must now be trained
Royal Pharmaceutical standards

e all your employees trained?
hat about new, part-time and
turday staff?

unterpart is recognised by the
ciety and accredited through the
llege of Pharmacy Practice

in the form now to get a complete set of training modules, questions
d a briefing pack for just £17.63 (inc VAT). Each pack covers up to
r assistants.

ch assistant must be registered for telephone marking and CPP
tificate at a cost per person of just £29.38 (inc VAT).
t each candidate by first and last name

Pharmacist

Pharmacy

Address

Post Code

Telephone

Fax

Name	£	
Name	£	
Name	£	
Name	£	
Name	£	
Sub total	£	
Please include ( ) complete sets of counterpart modules 1-14 at £17.63 each (inc VAT)	£	
Total	£	

Make cheques payable to Miller Freeman UK Ltd and send to Mary Prebble, Pharmacy Editorial Projects, Chemist & Druggist, Miller Freeman House, Sovereign Way, Tonbridge TN9 1RW

For further information contact John Skelton on 01732 364422

Manek delivers 100% growth in just over 2 years*

2nd out of 267 funds in 1999**

Jayesh Manek, twice winner of the Sunday Times Fantasy Fund Manager contest, launched the Manek Growth Fund in December 1997.

The Fund has significantly outperformed the FTSE All Share Index and other funds in its sector, including Index Trackers.

£6,000 invested at launch in the Manek Growth Fund had grown to £12,048 by 2 February 2000, a return of 100%*. This compares with a rise of 27% for the average UK All Companies unit trust. The Fund was 2nd out of 267 funds in 1999.**

The Fund's objective is simple. To provide investors with long-term capital growth. The investment strategy is based on identifying individual companies in the UK and abroad – across all sectors – whose share prices have the potential to outperform.

With over £200 million' under management, Manek's strategy continues to focus on identifying stocks with the ingredients to deliver exceptional growth. He has no institutional constraints on his flexibility to adopt the most appropriate investment strategy. He has a direct and personal interest in ensuring that the Fund continues to outperform the Indices and grows your investment over the long term.

You can invest up to £7,000 in our Maxi ISA or up to £3,000 in our Mini ISA in the current tax year. You may also transfer your existing PEPs from another manager to the Manek Growth PEP.

For full details and application forms, call now quoting Ref: CD1803, visit our web site or return the coupon below.

Freefone: 0800 783 6060
www.manek.co.uk

Manek Growth ISA

To: Investor Services, Manek Investments, Bristol BS38 7PY

Title _____ Surname _____

Forename(s) _____

Address _____

_____

_____

Postcode _____ Ref: CD1803

Manek investments

A winning performance

Source Reuters Hindsight * offer to bid, net income reinvested, 16/12/97 - 2/2/2000 ** offer to bid, net income reinvested, 1/1/99 - 31/12/99 *As at 2 February 2000. Investments in the Manek Growth Fund, an authorised unit trust, should be made only on the basis of the Scheme Particulars and Key Features documents which may be obtained from Manek Investments. Please remember that the value of units and the income from them may go down as well as up and it may be affected by exchange rate variations and, you may not get back the amount invested. Current tax levels and reliefs may change and their value will depend on your individual circumstances. Calls may be recorded for your own protection. Past performance is not necessarily a guide to future performance and you should regard an investment in a unit trust as a medium to long term investment. Manek Investment Management Limited is regulated by IMRO and the Personal Investment Authority.